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COORDINATING HEALTHY PUBLIC POLICY

**AN ANALYTIC
LITERATURE REVIEW
AND BIBLIOGRAPHY**

Canada

COORDINATING HEALTHY PUBLIC POLICY

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OVERVIEW

The interest guiding our literature review was not so much the content of healthy public policy but the processes by which it may be achieved. We found the literature of healthy public policy itself to be largely exhortatory: it was proscriptive rather than empirical in nature. The literature appears to be highly redundant: the same ideas seem to be re-worked and traded back and forth, in a process leading to a shared view or ideology concerning healthy public policy and how to coordinate it. The literature is not, for the most part, theoretically grounded.

Coordinating and implementing healthy public policy are social processes which involve developing and channeling human motivations, the creation of social institutions, modifying the relationship between the individual and societal institutions, mobilizing collectivities to action, and other fundamentally social processes. Yet this literature does not reference the literature of the social sciences. A useful research strategy would be to bring social science theory explicitly to bear on the issues of coordinating healthy public policy. Our review therefore attempts to make linkages between the social science literature and the literature which is specific to the healthy public policy field.

The purpose of this Final Report is simply to overview the major issues which are analyzed in some detail in the accompanying document, **Coordinating Healthy Public Policy: An Analytical Review and Bibliography**. That document makes extensive reference to a wide range of literature in the area of healthy public policy and in broader areas which have the potential to contribute to the knowledge base guiding research in the coordination of healthy public policy.

CONCEPTUAL ISSUES

The research base in the area of coordinating healthy public policy reveals a wide variety of definitions. Conceptual ambiguity exists concerning such issues as the difference, if any, between healthy public policy, public health policy and health promotion policy. Research in the area will be enhanced by careful attention to conceptualization and to definitional precision. The definitions advanced in World Health Organization documents and in *Achieving Health for All* (1986) are recommended. Health promotion is conceived as "the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health" (*Health Promotion: Concept and Principles*, 1986). Healthy public policy is distinguished from traditional medical care policy by being

"ecological in perspective, multisectoral in scope, and participatory in strategy" (Milio, 1987a, 1987b). Health promotion is one particularly appropriate strategy for improving health, particularly within developed nations. In the developing world, however, emphasis is likely to be given to the provision of primary health care services.

Canada has remained in the forefront of development in both health promotion and healthy public policy since the publication in 1974 of *A New Perspective on the Health of Canadians*, and the establishment, in 1978, of the Health Promotion Directorate. However, in Canada as elsewhere, attention has until recently primarily been paid to individualistic efforts to change health behaviours rather than to enhance health through multisectoral approaches. The conceptualization of health promotion, however, has shifted in recent years toward a multisectoral approach which attends to the historical and socio-structural contexts of health and healthy behaviour. Recent Canadian multisectoral approaches involving healthy public policy initiatives in the areas of smoking, drug use and traffic safety provide research opportunities to learn more about coordination when such programs cross both sectoral and jurisdictional lines. These new approaches begin to make health promotion congruent with healthy public policy.

Although the field of healthy public policy is still conceptually underdeveloped, attention is already shifting from conceptualization to implementation. This is occurring at all jurisdictional levels from the international level to national, regional and local-community levels. In this shift toward implementation, the customary stages of operationalization of concepts and development of appropriate indicators to assess the extent of success in implementing healthy public policy have been, for the most part, overlooked. In order to organize a review of the literature in this area, and to identify research needs, it was necessary to develop a conceptual framework. This framework makes an analytic distinction between the process of **developing** coordinated healthy public policy and the process of **implementing** coordinated healthy public policy.

THE PROCESS OF DEVELOPING HEALTHY PUBLIC POLICY

While literature, particularly literature informed by research, is sparse in the new area of healthy public policy, there exists a wealth of applicable literature in the more general fields of policy analysis,

political science, and sociology which can be brought to bear on the process of developing healthy public policy. Both concepts and research techniques can be taken from these fields.

The process of developing healthy public policy is marked by complex conceptual and practical demands: that it be **multisectoral and multidisciplinary**, that its problems are **multifaceted**, that it views human activity in **environmental and ecological contexts**, and that it be **participatory** (*Health Promotion: Concepts and Principles*, 1986). Drawing on reports of examples of innovations and on the much more frequent non-empirical discussions of innovations, we provide an overview of the preliminary steps in the policy process, those which deal with the formulation or development of public policy. We discuss barriers to the formulation of healthy public policy, and suggestions to overcome them.

Three approaches to public policy making have been identified by Ziglio (1987a), drawing on Etzioni (1967): The **rational-deductive** approach, **incrementalism**, and the **mixed-scanning** approach. The latter appears to be the most appropriate for the development of healthy public policy. Mixed-scanning approaches combine pursuit of long-range goals with the intention to attain rationality with an incremental approach.

Conceptual frameworks found in social policy, ecology and policy studies are useful, but need to incorporate the environment within which healthy public policy is to be undertaken. Different theoretical approaches assume varying degrees of consensus or conflict in that environment, and attribute varying importance to the role of interest groups and of widespread public participation in the policy process. Some theoretical approaches, which emphasize corporatist ideas about the importance of specific interest groups, appear to run counter to the prevailing ideology of healthy public policy, which stresses the importance of broadly based individual and community participation in healthy public policy initiatives. Important research needs emerge in the area of the relationship between the state, interest groups, and the citizenry.

The design of healthy public policy, like policy design in general, is probably most needed under conditions which make it the most difficult to achieve, namely, conditions of uncertainty.

Many in the healthy public policy field emphasize the importance of "vision" and "shared values" as a basis for the development and implementation of initiatives. "Visioning processes" and "proactive planning" invoke a model in which shared or collective authorship of a vision of a healthy future is held to be either a necessary prerequisite for, or a strong facilitator of, healthy public policy development. The "Healthy Cities" movement (Duhl, 1986a) is an example. The notion that a shared vision facilitates the coordination of healthy public policy is not grounded theoretically (it would be consistent with some ap-

proaches such as structural-functionalism but inconsistent with approaches such as conflict or marxian theories); nor has it been examined empirically.

Goal-setting is another component of the policy process that is widely advocated and, to some extent, realized as in the Quebec Report, *Objectif Santé* (1984) and the Ontario report, *Health for All Ontario* (1987). The relationship between somewhat abstract goals, more concrete objectives and behavioural or organizational outcomes is again not clearly addressed theoretically, nor examined empirically.

THE PROCESS OF IMPLEMENTING HEALTHY PUBLIC POLICY

We have drawn explicitly on concepts from the area of planning to organize the literature concerning implementation of healthy public policy. The notions of policy-making and planning often appear to be used interchangeably. However, we view planning as an instrument for the realization of policy. Social change, with concomitant generation of uncertainty, increases the importance of planning. In addition, increasing complexity of the environment, such as is occasioned whenever policy crosses sectoral or jurisdictional boundaries, or whenever the number of players and participants is increased, also heightens the need for planning. As these are all conditions endemic to the coordination of healthy public policy, it is regrettable that planning for implementation has been hitherto neglected in the literature.

Both the possibility and the legitimacy of planning have been debated. In addition to such a barrier to planning as fear of change, resistance to change by powerful interest groups and the lack of technology of "know-how" to plan for change have been identified as barriers. Rational planning models have been judged inadequate to overcome these barriers because, in part, they neglect the implementation stage and because they cannot cope with incomplete knowledge and uncertainty.

Policy implementation may also fail to realize formally stated goals but serve hidden, unintended or symbolic functions. The dispute between proponents of 'top-down' and 'bottom-up' approaches to policy implementation has been vigorous and affects the legitimacy of planning in the minds of various audiences. Recently, attempts at reconciliation between proponents of both approaches have been made. Effective implementation is held to require not only clear and consistent objectives and the support of central authorities but also committee and skillful implementing officials and the support of interest groups. It also requires supportive socioeconomic and political conditions which enhance public support. A major priority for research in the coordination of healthy public policy initiatives must address the conditions under which varying degrees of centralization enhance or impede implementation.

Research should also investigate the extent to which ambiguity, rather than clarity, of research goals facilitates implementation. Planning for implementation is a political process requiring resource allocation, negotiation and compromise. The extent to which consensus is a prerequisite for effective policy implementation is very much open to debate.

Finally, our research has emphasized the need to examine, through research, the impact of the social and political macro-environments on all phases of the healthy public policy process. As Milio argues (1987a), research attention to the "social climate" of policy in general, and health promotion in particular, is needed.

In summary, the characteristics of healthy public policy, namely that it is multisectoral, participative, multidisciplinary, and focuses on issues of equity in health, generate a need for new or revised processes of developing and implementing public policy.

MECHANISMS FOR COORDINATING HEALTHY PUBLIC POLICY

Healthy public policy appears to require new arrangements between and within organizations which facilitate communication and cooperation. While it is recognized that coordination in Canada is complicated by the constitutional separation of powers between the federal and provincial governments, our review has emphasized intersectoral rather than interjurisdictional coordination.

Our review suggests that coordination is defined in many ways or, as in *Achieving Health for All* (1986), it is not defined at all. In that document, however, its implicit connotation is strongly suggestive of collaboration. As such, coordination demands new approaches to policy development and implementation and new structures to support such efforts. Milio (1987a) suggests that three approaches to healthy public policy predominate, a **targeted** approach, a **policy planning structures** approach, and a **participatory structures** approach.

Targeted approaches aim at specific areas of policy such as food and nutrition or cardiovascular disease. Many recent Canadian initiatives in healthy public policy can be viewed as targeted approaches. Policy planning structures approaches are those in which mechanisms for intersectoral planning and policy development are developed, spanning sectoral domains. Examples would be the Interministerial Committees established as part of the Swedish health strategy for the 1990s, and the interministerial committee recently formed in Ontario in response to recommendations of the report, *Toward a Shared Direction for Health in Ontario* (1987), of the Ontario Health Review Panel. The participatory structures approach addresses the need for widespread public participation in the policy process. It has been used in the development of women's health policies in

Australia and New Zealand. It is possible to combine these approaches and, in fact, this has occurred.

When effective collaboration in healthy public policy is not attained, the failure is sometimes attributed to a lack of "political will". Other barriers are probably more important but in any case easier to measure: lack of cooperation by stake-holders with competing interests or at different jurisdictional levels, difficulties in mobilizing public support, inexperience in the policy process, inadequate knowledge base, or ideological differences between advocates of centralist approaches and those of "grass-roots" approaches.

Research on interorganizational relations identifies a number of conditions that may facilitate collaboration for healthy public policy. Collaboration is enhanced when stakeholders appreciate their interdependence, when the policy process is implemented by interests with high legitimacy, and when alternatives to collaboration, such as litigation, are perceived as more costly (Gray, 1985).

As a general comment on the field, it may be concluded that the empirical basis upon which to draw conclusions about factors affecting the success of healthy public policy coordination is shaky. While there is little in the way of formal evaluation or analysis of coordination mechanisms, there is a growing number of examples of attempts to coordinate healthy public policy initiatives at local and national levels. Milio (1987a) provides a rich resource of structural and procedural variations in healthy public policy around the world, and Canadian examples, noted in our Analytic Review, are growing in number. Research attention to individual initiatives, as well as comparative research, would enrich our understanding of the coordination process.

RESEARCH ON HEALTHY PUBLIC POLICY

On the basis of our review, several content areas for research can be recommended, alternative designs can be discussed and mechanisms to facilitate research on the topic of coordinating healthy public policy can be proposed.

Seven content areas are discussed in the accompanying report.

- (1) Analyses of the theory underlying healthy public policy and its coordination would enrich the research endeavour in this area and increase both its rigour and general application.
- (2) The increasing number of examples of healthy public policy initiatives, in Canada and internationally, should be studied individually and comparatively. We are not proposing solely evaluative research (although this will be useful), but systematic descriptive and analytical studies which will enhance our understanding of the mechanisms which facilitate the develop-

ment, implementation and coordination of healthy public policy initiatives.

- (3) Studies are needed of the feasibility of various mechanisms for implementing and coordinating healthy public policy initiatives, paying particular attention to barriers to policy development and implementation.
- (4) Studies of the effects of context upon implementation will provide a more realistic understanding of both barriers to and facilitating conditions for healthy public policy initiatives.
- (5) Studies of coordinating mechanisms are needed, particularly of those dealing with intersectoral and interjurisdictional coordination.
- (6) Studies of the health effects of healthy public policy must examine the extent to which healthy public policy makes a difference at all. These studies, to be effective, will require a stronger measurement base.
- (7) Studies identifying indicators of the presence of healthy public policy are required to develop indicators which take different units of analysis (the individual, the community, the organization, the society, etc.) and which measure all aspects of the development, implementation and coordination of healthy public policy.

Turning to research design issues, we recommend that both qualitative and quantitative approaches be employed for research in this area, that both retrospective and prospective studies be conducted, and that action research be included in the set of approaches to be supported. Taken together, these constitute a recommendation for a very flexible approach to research, one which takes into account the rapidity with which the coordination of healthy public policy has become a salient issue in Canada and many other nations, and one which recognizes the present state of knowledge underdevelopment at this time.

Finally, a wide range of approaches can be taken to facilitate healthy public policy research, including research dealing with its coordination. Interdisciplinary research centres would be useful and could provide additional incentives to individuals through career development awards. Funding priorities

should recognize the importance of research in the coordination of healthy public policy.

REFERENCES

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- Achieving Health for All: A Framework for Health Promotion.* Ottawa: Health and Welfare Canada, 1986.
- Duhl, Leonard J. *Health Planning and Social Change.* New York: Human Sciences Press Inc., 1986a.
- Etzioni, Amitai. Mixed Scanning: A "Third" Approach to Decision-Making. *Public Administration Review*, 27 (Dec.), 1967: 385-92.
- Gray, B. Conditions facilitating interorganizational collaboration. *Human Relations*, 38(10), 1985:911-936.
- Health for All Ontario.* Report of the Panel on Health Goals for Ontario. August 1987.
- Health Promotion: Concept and Principles In Action, A Policy Framework.* Unpublished discussion document. Copenhagen: World Health Organization, Regional Office for Europe, 1986.
- Milio, Nancy. *Healthy Public Policy: Issues and Scenarios.* Unpublished paper prepared for A Symposium on Healthy Public Policy, Yale University, October 5-6, 1987a.
- Milio, Nancy. Personal Interview. October 28, 1987b.
- Objectif Santé. *Rapport du comité d'étude sur la promotion de la santé.* Québec: Conseil des affaires sociales et de la famille, 1984.
- Toward a Shared Direction for Health in Ontario.* Report of the Ontario Health Review Panel. June, 1987.
- Ziglio, Erio. Policy-making and planning in conditions of uncertainty: Theoretical considerations for health promotion policy. Draft working paper No. 7, Research Unit in Health and Behavioral Change, Edinburgh, Scotland, 1987a.

Chapter One

INTRODUCTION

This report provides an analytic literature review on one element of the Health Promotion Framework contained in the report, *Achieving Health for All* (1986). The focus of our work has been on the literature pertaining to the coordination of healthy public policy. The goal of this report, and of the other reports dealing with elements of the Health Promotion Framework, is to contribute to a research strategy which will facilitate the implementation of the recommendations made by the Canadian government in *Achieving Health for All*.

We were charged with reviewing the relevant literature, delineating the methodological issues and indicator requirements associated with the subject area, and outlining future research needs. The mandate of the review was to generate information that will prove useful to those who are involved in recommending research priorities in the overall area of health promotion.

The Health Promotion Framework consists of a set of challenges, mechanisms and strategies, all of which are linked such that the interaction between mechanisms and strategies in addressing the challenges is as much a part of the framework as the nine conceptual "cells". Consequently, some attention is given in our review to research questions dealing with fostering public participation.

The rationale behind the strategy of "coordinating healthy public policy" is the belief that public policies, in general, act as incentives or disincentives to health. Policies that concern, for example, nutrition, housing, defence and recreation all have an impact on preventing health problems or actually enhancing the health status of the population. What is needed are public policies that make it easier for people to live healthy lives and make healthy choices. Policies that prohibit smoking in public places are one example of this effect. Policies that enhance the economic ability to secure adequate nutrition and housing are also examples. It is evident that healthy public policies extend well beyond the domain traditionally thought of as "health". It is clearly necessary, however, to ensure that a measure of coordination exists between the various types of policies and policy-making bodies in this wider health domain, so that they reinforce rather than undermine one another.

INFORMATION GATHERING

Our review of the literature on coordinating healthy public policy consisted of four separate activities. A computer search was conducted at the outset, employing such key words as "public health policy" and "health policy". An extensive library search was also done, including a search of relevant abstract and index sources. Further information was gathered through consultation with a number of experts in the field. These included: Dr. Trevor Hancock, public health consultant, Toronto; Dr. Rhonda Love, Dept. of Behavioural Science, University of Toronto; Dr. Alexander Macpherson, Medical Office of Health, Toronto; Dr. Nancy Milio, University of North Carolina. Finally, members of our research team were able to collect useful information through attendance at a series of conferences. These consisted of The Canadian Institute of Planners (July 1987, Toronto); the WHO-sponsored conference, "The New Public Health: Implications for Research" (October 1987); "Changing the Public Health" (October 1987, University of Edinburgh) and the Ontario Public Health Conference (November 1987, Toronto). These four sources of data constitute the basis of this report.

OVERVIEW OF THE REPORT

The chapters which follow describe the literature using a conceptual framework developed during our research.

Chapter 2 provides an overview of the conceptual domain of healthy public policy. Definitions are provided for the set of concepts related to healthy public policy. These are then placed within the broader history of developments in health promotion. Finally, major issues in the field of healthy public policy are identified by examining several recent documents and reports dealing with health promotion and related areas.

Chapter 3 deals with the processes by which healthy public policy can be achieved. It begins with a definition of policy and an overview of the policy

process. This is followed by a discussion of the limitations of traditional assumptions in this area. Healthy public policy must be multisectoral, multidisciplinary, multifaceted and participatory. This unique combination of characteristics requires new, complex assumptions and formulations which are suggested in this chapter.

In Chapter 4, the process of implementing healthy public policy is reviewed. The environmental context in which healthy public policy is formulated is also discussed and its influence on the process is analyzed. Attention focuses on the approaches to planning and to the dilemmas posed by various models for the values underlying healthy public policy.

Chapter 5 focuses on mechanisms of coordination. A general outline is provided of issues important to the coordination process. Theoretical material on inter-organizational conflict and collaboration is then reviewed. The chapter concludes with a discussion of a number of actual experiences with healthy

public policy that have occurred in various jurisdictions, ranging from the national to the local level.

Chapter 6 examines the research implications of the issues discussed in the previous chapters. Potential content areas, appropriate research designs and mechanisms required to facilitate research in this area are all addressed. Suggestions regarding future directions for research on the establishment and coordination of healthy public policy are outlined. A comprehensive bibliography of the literature on coordinating healthy public policy, categorized by major topical areas, is appended to this report.

REFERENCES

Achieving Health for All: A Framework for Health Promotion. Ottawa: Health and Welfare Canada, 1986.

Chapter Two

CONCEPTUAL OVERVIEW AND HISTORICAL BACKGROUND

This chapter provides an overview of the conceptual domain of healthy public policy. Precise definitions are given of the set of concepts related to healthy public policy. This conceptualization is placed within the broader history of developments in health promotion. As well, the major issues in the field of healthy public policy are identified through an examination of several of the recent significant documents and reports on health promotion produced both in Canada and elsewhere.

CONCEPTUAL AND DEFINITIONAL OVERVIEW

There is some conceptual and definitional confusion in the literature as to what constitutes healthy public policy. This section, therefore, aims to reduce some of the confusion by providing working definitions of key terms as they are used within this review.

Underlying the conceptual overview provided here is a principle of consistency; that is, it is presumed that there ought to be a logical relationship between how one defines health, what one defines as a health problem, and what one ultimately identifies as potential solutions to such problems. Given this notion of consistency, it is argued that the notion of healthy public policy as an implementation strategy for health promotion is logically derived from a particular view of health which in turn implies a particular conception of what constitutes a health problem.

Definition of Health

Achieving Health for All: A Framework for Health Promotion outlines a "new vision for health" (1986:3) which builds explicitly on the Health Field Concept of *A New Perspective on the Health of Canadians* (Lalonde, 1974) and the World Health Organization's current conception of health. The Health Field Concept proposes that human health is influenced by a range of factors which includes human biology, individual lifestyle, the social and physical environment, and the organization of the health care system.

The World Health Organization conceives of health as ...the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs, and, on the other hand, to change or cope with the environment (*Health Promotion: Concepts and Principles, In Action, A Policy Framework*, 1986:4). [Hereafter referred to as *Health Promotion: Concepts and Principles*, 1986.]

Together, these conceptions of health recognize that health does not result merely from the avoidance of disease. Rather, this view of health is "ecological" (Milio, 1986a), recognizing the link between human health and the social and physical environments. A distinction might be made between "ecological" and "environmental" on the grounds that the latter refers to the various aspects of the environment as the context for human life whereas the former refers to interaction between humans and all aspects of their environment. Further, health is viewed as a resource for living. This view means that issues of quality of life in addition to life expectancy become important. Such a conception of health implies that more than a medical care system is needed to improve health. Hence, for example, efforts to improve the physical environment are appropriately considered as health issues because of the influence the physical environment exerts upon human health.

While this view of health is receiving support from some people, it is not without its detractors, who claim, for instance, that such a broad view of health is an example of "empire building" by health administrators and bureaucrats (Foster, 1987) or that it is hopelessly "utopian" (Strong, 1986). Another charge that has been laid at this conception of health is the threat of "healthism" in which the goal of all activities becomes health (Crawford, 1977). Similarly, "given the dominance of medicine over matters called problems of health", such a conception of health increases the threat of the medicalization of problems which have hitherto not been within the physician's domain of activity (*Vienna Dialogue*, 1987). These serious concerns with respect to the conception of health promulgated by the WHO (*Health Promotion: Concepts and Principles*, 1986:4)

are acknowledged but minimized in the comment, "Health is, therefore, seen as a resource for everyday life, not the objective of living..."

Critiques such as these will continue so long as a broad view of health is endorsed. Moreover, such critique plays an invaluable role in contributing to the clarification of concepts. It is in response to critiques such as those offered by Labonte and Penfold (1981) and Crawford (1977), for instance, that the substantive content of health promotion documents has changed in the past few years.

Definition of Health Promotion

The definition of health promotion used in this review derives from the ecological notion of health outlined above. It has been proposed by the WHO (*Health Promotion: Concepts and Principles*, 1986) and endorsed in *Achieving Health for All* (1986). There has been, however, much debate in the literature as to the meaning of health promotion (e.g. Kickbusch, 1984; Labonte and Penfold, 1981). One aspect of this debate originates from health promotion initiatives which are essentially adaptations of the techniques of marketing to the dissemination of health information. As a result of such initiatives, health promotion has been thought of as the promotion of health in the same way that one promotes toothpaste or automobiles (e.g. Williams, 1984; Player, 1986). Another concern that has plagued the conceptualization of health promotion has been the tendency to focus on changing individual behaviour (e.g. Lalonde, 1974). This emphasis on individual responsibility to the exclusion of any recognition of the structural determinants of social behaviour has led to charges of "blaming the victim" (Crawford, 1977; Labonte and Penfold, 1981; Ryan, 1971). Recently, the WHO (*Health Promotion: Concept and Principles*, 1986) has articulated a conceptualization of health promotion which is intended to link individual responsibility for health with social responsibility, thereby attempting to overcome the individualistic, victim-blaming tendency of earlier conceptualizations.

As previously noted, the WHO conceptualization of health promotion is consistent with an ecological view of health: health promotion is conceived of as "the process of enabling individuals or groups to increase control over and to improve their health" (*Health Promotion: Concept and Principles*, 1986:4). This conception of health promotion is intended to convey a positive approach to health, in keeping with the notion that health should be a positive experience, not merely the absence of a negative one. It stresses that health promotion should be a dynamic process involving people gaining control over their own health. This conceptualization also characterizes health promotion as "a mediating strategy between people and their environments, synthesizing personal choice and social responsibility in health to

create healthier futures" (*Health Promotion: Concept and Principles*, 1986:3).

It is important to recognize that this definition of health promotion is a recent one, and that practices associated with health promotion do not necessarily yet reflect the rhetoric of empowerment, community development, and social action on the determinants of health, which are central to this conceptualization. The WHO (*Health Promotion: Concept and Principles*, 1986) suggests that diverse activities such as education, legislation, fiscal measures, community development, and organizational change are all appropriate strategies for health promotion. These activities imply, however, a role for government which extends beyond traditional health education (see, for example, Allison, 1982; Love and Kalnins, 1984). Milio (1986a) argues that it is public policy the specific output of government which must be used as a strategy for health promotion. Milio (1986a:3) argues that public policy is the primary determinant of the health prospects of the population because it shapes "contemporary environments in communities, workplaces, homes, and schools". Public policy, she suggests,

...sets parameters for the mode and character of industrial and agricultural production, corporate management, and individual behaviour. By laying out the range of options from which organizations and individuals make their choices,...public policy is not only an influence on environment: it is an inextricable and critical part of today's and tomorrow's environment (Milio, 1986a: 3).

Thus, public policy contributes to the health of the population both directly (e.g. through establishing occupational health and safety guidelines) and indirectly (e.g. through taxes on alcohol and cigarettes). Increasingly, health advocates are calling for "healthy public policy" (e.g. Hancock, 1982, 1985a, 1985b; Milio, 1985a, 1985b, 1986a, 1987a, 1987b; *Health for All Ontario*, 1987).

Definition of Healthy Public Policy

Healthy public policy seems to have been plagued both by conceptual ambiguity and by variations in the literature in the terminology used to represent the concept. Healthy public policy has been variously conceived of as "policy of the people and their elected representatives characterized by an explicit concern for health" (*First Announcement*, 1987:1); as health-making policies (Milio, 1986a); as "multisectoral policies to achieve equity in health" (*Health Promotion: Concept and Principles*, 1986:19); and "public policy supportive of health" (*Health for All Ontario*, 1987:92). Reviewing the literature is further complicated by the use of the phrase "healthy public policy" interchangeably with "health promotion policy" and

"health promoting policy". The purpose of this section is, therefore, to outline how the term "healthy public policy" is used within the context of this review.

There is debate as to the origin of the term "healthy public policy", though Hancock (1982) was among the first to use it in the literature. Originally, Hancock (1982) distinguished between healthy public policy and public health policy, in which the latter is a narrow, sectoral set of policies aimed at the system of caring for ill people. (Hancock has used public health policy as an umbrella term which incorporates traditional health care system policy. Commonly, however, health care system policy is thought of as being concerned with hospital and physician-based care whereas public health policy has been seen as community-based.) According to Hancock's conceptualization, public health policy is characterized by being primarily concerned with the health care system, dominated by a high technology approach to medicine, sectoral and analytic, present-oriented, and accepting of the status quo. Hancock contrasted this set of policies with healthy public policy which, he argues, focuses on the determinants of health. Healthy public policy, as Hancock (1982:7) conceived of it, is "chiefly concerned with creating a healthy society", dominated by a low technology approach, "holistic", "future-oriented", and questioning of the status quo. Healthy public policy differs from public health policy by being multisectoral, that is, it explicitly recognizes the contribution made by various ministries to health (e.g. agriculture, education, transportation, energy, housing, etc.). Further, healthy public policy is founded upon public participation in policy formulation and implementation. Hancock does recognize that public health initiatives of the last century can be exempted from his indictment of public health. More recent writings by Hancock (1985a, 1985b) have consolidated these original ideas.

For the purposes of this review, healthy public policy is being used to refer to "public policy for health", using health in the broad, ecological sense previously outlined. While it is possible to conceive of health promotion policy as a collection of public policies which promote health, in our conceptualization, it is a sectoral policy of government aimed specifically at health promotion (Hancock, 1987). One example of a health promotion policy might be the recommendation to establish the new Health Promotion Branch in the Ontario Ministry of Health. Another example of a health promotion policy might be the establishing of a non-smoking policy for public spaces. These policies are characterized by the limited context in which they are enacted, namely, they do not cross sectoral boundaries (they may, however, cross jurisdictional boundaries). Healthy public policies are those which are developed through a multisectoral and collaborative

process which endeavors to ensure participation by the affected constituencies and which are unique for having an explicit awareness of their health implications. It is important to note that WHO uses the term "health promotion policy" as synonymous with the view of healthy public policy outlined here, and sees healthy public policy as supporting health promotion policy (see *Health Promotion: Concept and Principles*, 1986). Consequently, WHO materials have been reviewed as if the term "healthy public policy" were used, although most often the term "health promotion policy" is used.

Public policy for health is thus analogous to public policy for economic development in its scope and diversity. Many policies not explicitly falling under the domains of either the Ministry of Finance or Regional Economic Development, for example, have economic consequences; indeed, it would be difficult to imagine many public policies which did not have economic consequences. So too with health. Public policy for health extends beyond the traditional sector of health care and health care provision when it is recognized that policies for agriculture, income redistribution, child care, energy, and education to name but a few of the more obvious policy fields -all have an impact on health (Milio, 1986a). This is not mere empire building, as some critics charge, (Foster, 1987) but a recognition of the complexity of the determinants of health and disease, and the interdependence of the various sectors of contemporary society (Milio, 1986a).

Public policies for health have been characterized by Milio as "ecological in perspective, multisectoral in scope, and participatory in strategy" (Milio, 1987a, 1987b). Thus, healthy public policy incorporates a broad vision of health, crosses traditional departmental and ministerial boundaries, and involves dialogue between the policy makers and the "public", recognizing that there is no such thing as a homogeneous public.

"Healthy public policy" is a potent if not confusing phrase. Because of what Hancock (1987) refers to as its "grabber" appeal, the phrase "healthy public policy" will undoubtedly continue to be used, for that emotional appeal is not replicated in the less catchy but more grammatically correct "public policy for health". Nevertheless, these two phrases are fundamentally synonymous and will be considered so in this review.

Finally, it may be useful to think of healthy public policy as a concept which aims to suggest a new way of thinking about health and government policy that is participatory, multisectoral, and ecological. In this way, healthy public policy is an overarching notion that links policy sectors through a concern for health. While inevitably such a view of health has implications for the structure of government and the bureaucracy, these implications are not hierarchical, such that every department is subordinated to the

Ministry of Health. Rather, healthy public policy requires that coordinating structures and processes be developed in order to increase the awareness and attention given to the health implications of policy. It has been suggested that just as now all policies must be vetted by Treasury Board for their fiscal ramifications, in the future, all policies should also be reviewed by a National Health Board for their health implications (Duhl, 1986a; Milio, 1986a). The objective of healthy public policy is not to make health the only goal of public policy, but to put health higher on the political agenda.

HISTORY OF HEALTHY PUBLIC POLICY

The history of healthy public policy is in some ways as long as the history of public health, even though the term itself has only recently appeared (Hancock, 1982). Healthy public policy can be seen as a call to reconsider the roots of modern public health in the reforms in education, housing, sanitation, and immunization of the nineteenth and early twentieth centuries (Macpherson, 1987; *Healthy Toronto 2000*, 1987). In its contemporary form, however, healthy public policy is integrally linked to the World Health Organization and its recent strategy of Health for All by the Year 2000. A useful starting point, then, for considering the history of the notion of healthy public policy is to look at recent developments in WHO.

In 1977, the World Health Assembly endorsed a resolution that health was to be the main social goal of government and gave birth to the now famous Health for All by the Year 2000 movement (HFA 2000) (*Targets for Health for All*, 1985). The following year, a conference was held in Alma Ata, U.S.S.R. at which a declaration was made, calling for a renewed emphasis on primary health care, multisectoral action, and advocacy for public participation in health decisions. These latter two actions can be readily recognized as the major ingredients of healthy public policy. The Alma Ata declaration has been a powerful rallying cry for organizing health care in the developing world, though it has had little impact on industrialized nations already possessing a system of primary health care (Draper, 1987a). Following the Alma Ata conference, WHO worked on a strategy for HFA 2000 appropriate for the developed world.

In 1984, the European Strategy for HFA 2000 was released with targets for action identified in a target document (*Targets for Health for All*, 1985). The European Strategy represents a shift away from the technical and care-focused approach of primary health care to an emphasis on the social and environmental forces which interact to affect health (Draper, 1987a). The strategy calls for political actions that will address the health problems of in-

dustrial nations, with health promotion identified as one of four strategies to be used to attain HFA 2000 in Europe (the other three being primary health care, intersectoral action and the use of appropriate technology) (*Targets for Health for All*, 1985).

The inclusion of health promotion in the strategies for HFA 2000 provided important legitimization for the notion of health promotion as conceptualized by WHO (Draper, 1987a). Health promotion in the European Office of WHO emerged from the organization's earlier work in health education, in which it was discovered that in order to be effective in changing people's lifestyles, health education needed to be supported by more structural changes in society (Kickbusch, 1981, 1986). Early efforts in health promotion at WHO were primarily along the lines of social marketing. This approach proved to be a narrower view than what has ultimately been articulated by the European Regional Office (Draper, 1987a). A discussion document, *Health Promotion: Concept and Principles* (1986), which outlines the view of health promotion developed earlier in this review, was originally released in 1984 following a technical discussion in Copenhagen (it has subsequently been re-released). This document has been widely circulated and forms the basis of the conceptualization of health promotion found in Canada's *Achieving Health for All*.

Following the release of the health promotion discussion document, a conference was planned to be held in Ottawa in November 1986 which would focus on issues in health promotion in industrialized nations. This conference was marked by the release of the *Ottawa Charter on Health Promotion* (1986), which Draper (1987a) has characterized as a visible legitimization of health promotion as social, ecological, political, and comprehensive. Also held in 1986 was a technical discussion to consider the issue of multisectoral action as an element of HFA 2000. The meeting resulted in the publication of a document on intersectoral cooperation in health which is a seminal work on the topic of healthy public policy (*Intersectoral Action for Health*, 1986).

Today, activities associated with health promotion and healthy public policy are occurring at all levels, ranging from international to local. For example, the Healthy Cities project (Duhl, 1986a, 1986b; Ashton, Grey, and Barnard, 1986; Hancock and Duhl, 1986) currently under way reflects the excitement and interest in healthy public policy at a local level. Spawned by initiatives in Toronto, the Healthy Cities project embodies the notions of health promotion and the need for intersectoral action to improve health at the municipal level. Examples of regional initiatives include the diverse activities of the Regional Health Authority in Mersey (Ashton, Seymour, Ingledew, et al., 1986) and the establishment of the Health Goals for Ontario Panel (*Health for All Ontario*, 1987). At the national level, Norway's Food

and Nutrition Policy has attracted a great deal of interest among researchers, health planners, and politicians (see, for example, Milio, 1981). Internationally, a conference on healthy public policy is being planned for Adelaide, Australia in April, 1988. The purpose of the conference is to share experience and strategies for initiating and implementing healthy public policies. It is perhaps indicative of the rapid development of the field that even as we indicate the gaps in knowledge in the domain of healthy public policy, steps are being taken to close them.

CANADIAN DEVELOPMENTS IN HEALTH PROMOTION AND HEALTHY PUBLIC POLICY

The Canadian history of health promotion and healthy public policy is interwoven with the developments within the World Health Organization as Canada has been in the forefront of developments in health promotion since the publication of *A New Perspective on the Health of Canadians* (Lalonde, 1974). Building on the work of writers like McKeown (1976), *A New Perspective* was the first official government statement of its kind, a statement of the importance of shifting priorities for health investment and action (Evans, 1982). As noted previously, *A New Perspective* outlined the Health Field Concept which emphasizes that health is influenced by four areas, namely, lifestyle, human biology, environment, and the organization of health care. Of the recommendations contained in the Lalonde document, the need for changes in the individual lifestyles of Canadians dominated early health promotion activities of the federal government. These initiatives were in areas such as physical fitness, alcohol and drug abuse, and nutrition.

In 1978, the federal government restructured its Department of National Health and Welfare to include a Health Promotion Directorate, the first directorate of its kind in the world (Kickbusch, 1986). The early years of activity for the Directorate involved a large number of initiatives aimed at changing individual behaviour. More recently, efforts have shifted toward a broader view of health promotion, culminating in the 1986 publication of *Achieving Health for All: A Framework for Health Promotion*. This literature review is part of the ongoing development of the policies suggested in that publication. In addition, several innovative programs have recently been developed through a multisectoral, federal-provincial, consultative process in the areas of smoking and drug abuse (see for example, *Directional paper of the national program to reduce tobacco use in Canada*, 1987).

Events in several provinces also demonstrate interest in health promotion. Alberta's Health Unit Association (*Six Program Priorities for a Healthier Alberta*, 1985) has published a working paper on priorities for public health action until 1990 and 1995. While the major emphases in the paper are on issues such as cardiovascular disease, motor vehicle accidents and reproductive health, recommendations for action include environmental changes (e.g. water fluoridation) and the need for long-range planning for health. A report on health promotion was released in Quebec in 1984 (*Objectif: Santé*), appearing in English translation in 1986 (*Objective: A Health Concept in Quebec*). The report outlines an ecological view of health, the need for a social epidemiology, and proposes that what the province needs is a true health policy, that is, one which embraces an ecological view of health and does not restrict itself to consideration of the medical care system. Ontario has been highly involved in health promotion recently, as is evident from the release of three reports in the health field, the report of the Ontario Health Review Panel, *Towards a Shared Direction for Health in Ontario* (1987), the report of the Ontario Health Goals Panel, *Health for All Ontario* (1987), and the report of the Minister's Advisory Committee on Health Promotion, *Health Promotion Matters in Ontario* (1987).

It is noteworthy that initiatives have been taken at the provincial level consistent with the Health for All strategy. This trend suggests that there is some possibility for negotiating priorities between the federal and provincial governments.

Developments in the Department of Public Health of the City of Toronto, such as the formation of an Environmental Protection Unit in 1987 (City of Toronto Department of Public Health "Memorandum", 1987) and the City's participation with several others across Canada in the WHO Healthy Cities project, indicate that interest in healthy public policy and health promotion exists at the local level in some areas. The *Health Promotion Matters in Ontario* report (1987) provides an important supportive link between community-level and provincial-level health promotion policies.

Finally, Canada has witnessed the development of training programs focusing primarily on health promotion (e.g. the Master of Health Science program in Health Promotion at the University of Toronto) or which incorporate health promotion into existing curricula (such as in the Health Studies program at the University of Waterloo). Increased research interest within the academic community in health promotion could support and improve the trend toward health promotion in this country.

THE STATE OF THE ART IN HEALTHY PUBLIC POLICY

Early in the review process, a number of government reports and discussion documents were identified as "major" documents. The continuing literature review has been directed to topics in health promotion and healthy public policy which consistently appeared in these documents. The major documents initially reviewed were the following: *A New Perspective on the Health of Canadians*, (Lalonde, 1974); *Healthy People*, (1979); *Targets for Health for All*, (1985); *Health Education and Promotion in Victoria*, (1986); *Health for All 2000 and Health Promotion* (1986); *Achieving Health for All: A Framework for Health Promotion*, (1986); *Objective: A Health Concept in Quebec*, (1986); *Ottawa Charter on Health Promotion*, (1986); *Toward a New Direction for Health in Ontario*, (1987); *Health for All Ontario*, (1987).

Major Topics

Certain consistent themes and issues emerged in reviewing the documents noted above. Most of the documents provide a detailed analysis of the current status of health of the population, indicating the major patterns of mortality and morbidity, particularly the shift from communicable diseases to chronic diseases. Building on this analysis, most of the documents outline a vision of health which is consistent with the World Health Organization's conception of health and which links health status to conditions in the social and physical environment. Significantly, the reports argue that an increase in expenditure on medical care and facilities will not necessarily lead to continued improvements in health status on a population basis. Consequently, the documents call for initiatives in other domains besides medicine and an increase in individual, and in some cases social, responsibility for health. Thus, there is a call for health promotion generally, and healthy public policy in particular, to be used as strategies for improving health. However, these documents barely proceed beyond describing some of the characteristics of healthy public policy and prescribing areas in which it should be initiated.

The WHO *Targets for Health for All* document (1985:56) illustrates the prescriptive nature of the recommendations made in these key documents vis-à-vis healthy public policy: "...all Member States should ensure that legislative, administrative and economic mechanisms provide broad intersectoral support and resources for the promotion of healthy lifestyles and ensure effective participation of the people at all levels of such policy-making. Additional recommendations include reviewing existing policies to determine inconsistencies and contradictions such as subsidies for industries which produce harmful

substances, determining the health implications of existing policies, restricting the advertising of harmful products, and, above all, ensuring that "the general public ...be involved in policy and program development" (*Targets for Health for All*, 1985: 57).

This prescriptive and generalizing tendency reflects to some extent the political face of these major documents. The Lalonde Report was a political document, whose titular author was a cabinet minister in the government of Canada. Not surprisingly, it recommended very little that would embarrass the government financially, yet it professed concern with all aspects of health. The widespread acclamation of the Lalonde Report reflects the prevalence elsewhere in the world of an unwillingness to tackle the full range of obstacles to health (Buck, 1985:22).

The more recent documents (e.g. *Achieving Health for All*, 1986; *Health for All Ontario*, 1987) make more explicit reference to the politics of health, for example, by pointing out the inequities in health status associated with socioeconomic status. The aura of scientific objectivity and apoliticism which characterizes these major documents frustrates some readers (Strong, 1986). A more positive appraisal, however, suggests that these documents be regarded as visionary, providing a vision of a new direction for health, even though they provide little detail about how to achieve that vision.

The major topics in healthy public policy which emerge from these documents can be summarized briefly. Essentially, the state of the art is that the field is moving through a transition from conceptualization to implementation. The major documents are part of the articulation phase in which healthy public policy is described and advocated as a strategy for health promotion. Healthy public policy is deemed to require coordination but the major documents say relatively little about the development and implementation of coordinated healthy public policy. Thus, the current concerns in healthy public policy centre around the process and structures for developing and implementing intersectoral policies. These areas of policy development and coordination form the major emphases of the literature review. While the distinction between process and structure is to some extent an artificial one (for structures have implications for process and vice versa), these two topics are addressed separately for purposes of clarity. Finally, we consider the literature in this area to be largely non-empirical and theoretically weak. Most of the literature is not even descriptive; it is largely prescriptive; and many of the recommendations found in this literature have at best a tenuous grounding in established social science theory. We return to these problems in the concluding chapter of this work.

SUMMARY

This chapter introduced the conceptual and definitional domains of health promotion and healthy public policy. Definitions which are consistent in their underlying assumptions about the determinants of health were provided for health promotion and healthy public policy. These definitions are essentially those developed by the World Health Organization and adopted in *Achieving Health for All* (1986). Health promotion is conceived of as "the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health" (Health Promotion: Concept and Principles, 1986: 9). Healthy public policy is distinguished from traditional medical care policy by being "ecological in perspective, multisectoral in scope, and participatory in strategy" (Milio, 1987a, 1987b).

These conceptions of health promotion and healthy public policy have evolved within the context of developments in health promotion in the World Health Organization's recent *Health for All by the Year 2000* strategy. Health promotion has been identified as a particularly appropriate strategy for improving health within developed nations. This contrasts with the emphasis in the developing world on providing primary health care services for all.

Canada has been in the forefront of developments in health promotion and healthy public policy since the publication of *A New Perspective on the Health of Canadians* in 1974 and the establishment of the Health Promotion Directorate within Health and Welfare Canada in 1978. In Canada, as elsewhere, the early emphasis in health promotion was on individualistic efforts to change health behaviours, though this emphasis is changing in the rhetoric, if not the practice, of health promotion. To date, there have been a few attempts at developing and implementing healthy public policy on a national scale, specifically in the areas of smoking, impaired driving, and drug abuse.

The domain of healthy public policy is in the process of moving from conceptualization to implementation. Even as the concept is being refined, actors at all jurisdictional levels from international to local are moving to implement healthy public policy. The stage of operationalization of the concepts and the development of appropriate indicators appears to have been overlooked in this transition. The remainder of the literature review addresses the processes of developing, implementing, and coordinating multisectoral policies for health.

REFERENCES

- Achieving Health for All: A Framework for Health Promotion*. Ottawa: Health and Welfare Canada, 1986.
- Allison, Kenneth R. Health education: self-responsibility vs. blaming the victim. *Health Education*, Spring 1982:11-13, 24.
- Ashton, J., Grey, P. and Barnard, K. Healthy cities WHO's new public health initiative. *Health Promotion*, 1(2), 1986:129-133.
- Ashton, J., Seymour, H., Ingledew, D., Ireland, R., Hopley, E., Parry, A., Ryan, M. and Holbourn, A. Promoting the new public health in Mersey. *Health Education Journal*, 45(3), 1986:174-179.
- Buck, C. Beyond Lalonde creating health. *Canadian Journal of Public Health*, 76, Supplement 1, May/June 1985:19-24.
- City of Toronto Department of Public Health. Memorandum to Board of Health Concerning the Establishment of an Environmental Protection Office within the Department of Public Health. February 10, 1987.
- Crawford, Robert. You are dangerous to your health: the ideology and politics of victim blaming. *International Journal of Health Services*, 7, 1977:663-680.
- Directional paper of the national program to reduce tobacco use in Canada*. Consultation, Planning and Implementation Committee of the National Program to Reduce Tobacco Use, June 1987.
- Draper, Ron. Informal lecture given at Health and Welfare Canada, September 22, 1987a.
- Duhl, Leonard J. *Health planning and social change*. New York: Human Sciences Press, Inc., 1986a.
- Duhl, Leonard J. The healthy city: its function and its future. *Health Promotion*, 1(1), 1986b:55-60.
- Evans, Robert. A Retrospective on the "New Perspective". *Journal of Health Policy, Politics and Law*. 7(2), 1982:325-344.
- First Announcement*. Healthy Public Policy, 2nd International Conference on Health Promotion, April 5-10, 1988, Adelaide, South Australia. Copenhagen: World Health Organization, Regional Office for Europe, May 6, 1987.
- Foster, P. Health board heal thyself. *The Financial Post*, November 16, 1987:14.
- Hancock, Trevor. Beyond health care. *The Futurist*, August 1982:4-13.
- Hancock, Trevor. Health in transition. *Canadian Home Economics Journal*, 35(1), 1985a:11-13, 16.
- Hancock, Trevor. Beyond health care: From public health policy to healthy public policy. *Canadian Journal of Public Health*, 76, Supplement 1, May/June, 1985b:9-11.
- Hancock, Trevor. Personal interview. November 9, 1987.
- Hancock, Trevor and Duhl, Leonard J. *Healthy Cities: Promoting Health in the Urban Context*. Back-

ground working paper for the "Healthy Cities Symposium", Lisbon, Portugal, April 7-11, 1986.

Health Education and Promotion in Victoria. Report to the Minister of Health, June 1986.

Health for All Ontario. Report of the Panel on Health Goals for Ontario. August 1987.

Health for All 2000 and health promotion. Bloomsbury, London: Bloomsbury Health Authority, 1986.

Health Promotion: Concept and Principles, In Action, A Policy Framework. Unpublished discussion document. Copenhagen: World Health Organization, Regional Office for Europe, 1986.

Health Promotion Matters in Ontario. Report of the Minister's Advisory Group on Health Promotion, 1987.

Healthy People. The Surgeon General's Report on Health Promotion and Disease Prevention. Washington, D.C.: U.S. Department of Health, Education and Welfare, 1979.

Healthy Public Policy Strategies for Action: The Adelaide Recommendations. World Health Organization, 1988.

Healthy Toronto 2000. Toronto: Healthy Toronto 2000 Subcommittee, Board of Health, August 1987.

Intersectoral Action for Health. The role of intersectoral cooperation in national strategies for health for all. Geneva: World Health Organization, 1986.

Kickbusch, Ilona. Involvement in health: a social concept of health education. *International Journal of Health Education*, Supplement to XXIV, Issue 3, Oct./Dec. 1981:2-15.

Kickbusch, Ilona. Health promotion: A typology. *Health Promotion: Concepts and Principles*, A selection of papers presented at the Working Group on Concepts and Principles, Copenhagen, 9-13 July, 1984. Unpublished material received from World Health Organization, Regional Office for Europe.

Kickbusch, Ilona. Health promotion: A global perspective. *Canadian Journal of Public Health*, 77, Sept./Oct. 1986:321-326.

Labonte, Ronald and Penfold, Susan. *Health Promotion Philosophy*. Vancouver: Western Regional Office, Health Promotion Directorate, Health and Welfare Canada, 1981.

Lalonde, Marc. *A New Perspective on the Health of Canadians*. Ottawa: Government of Canada, 1974.

Love, Rhonda and Kalnins, Ilze. Individualist and structuralist perspectives on nutrition education for Canadian children. *Social Science and Medicine*, 18(3), 1984:199-204.

Macpherson, Alexander S. Personal interview. November 18, 1987.

McKeown, Thomas. *The Role of Medicine: Dream, Mirage or Nemesis?* London: Nuffield Provincial Hospitals Trust, 1976.

Milio, Nancy. Promoting health through structural change: Analysis of the origins and implementation of Norway's farm-food-nutrition policy. *Social Science and Medicine*, 15A, 1981:721-734.

Milio, Nancy. *Promoting Health through Public Policy*. Ottawa: Canadian Public Health Association, 1986a.

Milio, Nancy. Commentary: Creating a healthful future. *Community Health Studies*, IX (3), 1985a.

Milio, Nancy. Health nations: Creating a new ecology of public policy for health. *Canadian Journal of Public Health*, 76, Supplement 1, May/June 1985b:79-87.

Milio, Nancy. *Healthy Public Policy: Issues and Scenarios*. Unpublished paper prepared for A Symposium on Healthy Public Policy, Yale University, Oct. 5-6, 1987a.

Milio, Nancy. Personal interview. October 28, 1987b.

Objectif Santé. Rapport du comité d'étude sur la promotion de la santé. Québec: Conseil des affaires sociales et de la famille, 1984.

Objective: A Health Concept in Quebec. A Report of the Task Force on Health Promotion. Translated by M.S. Gayk. Ottawa: Canadian Hospital Association, 1986.

Ottawa Charter on Health Promotion. Ottawa: World Health Organization, Canadian Public Health Association, Health and Welfare Canada, November 1986.

Player, D. Health education and health promotion a positive approach. *Journal of the Royal Society of Medicine*, 79, Supplement 13, 1986:2-4.

Ryan, William. *Blaming the Victim*. New York: Pantheon, 1971.

Six Program Priorities for a Healthier Alberta by 1990 and 1995. A discussion document. Prepared for the Joint Long Range Planning Steering Committee of the Health Unit Association of Alberta, March 1985.

Strong, P.M. A new-modelled medicine? Comments on the WHO's Regional Strategy for Europe. *Social Science and Medicine*, 22(2), 1986:193-199.

Targets for Health for All. Copenhagen: World Health Organization, Regional Office for Europe, 1985.

Toward A Shared Direction for Health in Ontario. Report of the Ontario Health Review Panel. June 1987.

Vienna Dialogue on "Health Policy and Health Promotion towards a New Conception of Public Health". Copenhagen: World Health Organization, Regional Office for Europe. Unpublished document ICP/HSR 623, 1987.

Williams, G. Health promotion—caring concern or slick salesmanship? *Journal of Medical Ethics*, 10, 1984:191-195.

Chapter Three

THE PROCESS OF DEVELOPING HEALTHY PUBLIC POLICY

The overriding question guiding our literature review was not so much the content of healthy public policy, but how it is achieved. There exists a wealth of material in the fields of policy analysis, political science and sociology that may be instructive in the development of healthy public policy. There is much scope for conceptual borrowing and using techniques and research approaches from these fields to address the particular problems of public policy for health. This chapter, then, draws upon these other fields to present a conceptual overview of issues relevant to developing healthy public policy.

The chapter begins with a definition of policy and a brief overview of the policy-making process. The process of developing healthy public policy is marked by complex conceptual and practical demands, i.e. it should be multisectoral and multidisciplinary, its problems are multifaceted, it views human activity in its environmental context, and it should be participatory (*Health Promotion: Concept and Principles*, 1986). The chapter discusses the reconceptualization of health policy that these features would entail.

Throughout the chapter, samples of innovative literature have been integrated into the discussion to provide a resource for developing healthy public policy. The last section of the chapter, however, deals especially with vision, values and goals, the dimensions of healthy public policy with which Canada has some recent experience.

THE POLICY-MAKING PROCESS

Policy Analysis

There are a variety of ways in which policy can be examined, all of which fall under the rubric of 'policy analysis'. Ham and Hill (1984) present a useful topology of seven varieties of policy analysis. Studies of **policy content** seek to describe and explain the genesis and development of particular policies. Typically, one or more cases are studied in order to trace how a policy emerged, how it was implemented and what were its results. Studies of **policy process** focus on the stages through which issues pass, and attempt to assess the influence of different factors on the development of the

issue. Uncovering the various influences on policy formulation is a principal interest. Studies of **policy outputs** seek to explain why levels of expenditure or service provision vary between areas. Such studies take policies as dependent variables and attempt to understand them in terms of social, economic, technological and other factors. **Evaluation studies**, sometimes called impact studies, are concerned with analyzing the impact policies have on the population. **Information for policy-making** marshals a variety of data from various sources in order to assist policy-makers to reach decisions. **Process advocacy** is a variant of policy analysis in which analysts seek to improve the nature of policy-making systems, for example, through the reallocation of functions and tasks of the machinery of government, for example. Finally, **policy advocacy** involves the analyst, as an individual or through a pressure group, in pressing specific options and ideas in the policy process. These seven types of policy analysis Ham and Hill divide into analysis of policy (the first three) and analysis for policy (the latter three), with evaluation studies straddling the fence and used in either way.

Healthy public policy, as we have defined it earlier, can be considered to be "policy of people and their elected representatives characterized by an explicit concern for health" (*Vienna Dialogue*, 1987:1). Blum (1981:229) presents a definition of policy which probably represents the conventional working definition and sets out basic parameters that specific healthy public policies could include:

Policy is a long-term, continuously used, standing decision by which more specific proposals are judged for acceptability. It is characterized by behavioural consistency and repetitiveness on the part of those who make it and those who abide by it....**Public policy** is an established and legislatively enacted proposal by a public body duly constituted to make policy in the area of concern. It stipulates ends and it may provide resources. It may spell out specific means to reach these ends.

That being said, it is worthwhile to consider that policy may be a more slippery concept than the quote

from Blum suggests (Ham and Hill, 1984:101). Blum himself (1981:230) also adds the dimension of explicit versus implicit policy. The former refers to policy that may exist in a constitution or be spelled out in the preamble to laws. Implicit policy refers to a policy which on retrospection is always at work, but which may have escaped explication because it is taken for granted.

Wildavsky (1979:387) describes policy as process as well as product: "It is used to refer to a process of decision-making and also to the product of that process". Ham and Hill (1984:11) refer to several definitions of policy, variously as "a course of action or inaction", "consisting of a web of decisions and actions that allocate values", or "a set of interrelated decisions concerning the selection of goals and the means of achieving them within a specified situation". This chapter attends to the policy process, to the process of selecting goals and means, rather than considering the product, the actual content of healthy public policies.

Dror (1971), however, identifies three levels of policy that are also conceptually relevant: metapolicy, megapolicy and specific policy. Metapolicy is defined as policy on how to make policy, that is, the policy or rules by which decision makers will establish all other policies. Draper's (1987a) contention that healthy public policy should be formulated through a process that is multisectoral, participatory, and involving advocacy, is an example of a metapolicy statement because it sets the parameters of the policy-making system's mode of operation.

Megapolicy is a set of master policies which provides general guidance for more discrete specific policies. Reeves, Bergwall and Woodside (1984:200) provide an illustrative list of issues to be addressed through megapolicy, including organizational roles, values (e.g. quality versus cost), the theory on which decisions will be based, definition of health system boundaries and mission, the nature, extent and timing of intended changes, levels of acceptable risk, and similar issues.

Dror (1971:63) argues that the establishment of overall goals to serve as guidelines for large sets of concrete policies is a principal requirement of preferable megapolicy. Under various rubrics such as goals, targets and objectives, this element has been important in many healthy public policy documents. Some efforts to establish overall goals have already been undertaken in the Canadian context (*Health for All Ontario*, 1987).

At the level of specific policies, Blum's (1981) definition cited above begins to hold. Recent specific policy examples of healthy public policy could include the Canadian federal government's policies on smoking and drug abuse (Pinder, 1987).

Reeves, Bergwall and Woodside (1984:202), however, would add another component to the definition of policy, a condition necessary to translate policy advice into policy action: "A specific policy constitutes legitimate authorization for a designated agent to act in a particular way whenever a particular condition exists". This question of the nature of authority in the policy process is relevant to the implementation of existing policies, but also to the question of who legitimately can determine policy. The issue of participation in the policy process and of implementation in particular will be discussed later in the chapter. The point to be taken here is that policy also involves authority or, in a broader sense, power: power to control the emergence of issues, power to influence the formulation and implementation of policies, and power to restrict or enhance the degree of change (Crichton, 1981).

The Policy Process

Lee and Mills (1982:21) outline the policy-making process as follows: Ideas are developed and policies are formulated; policies are transformed into a set of objectives; objectives are converted into plans through the process of planning; plans are translated into a sequence of commitments and actions leading to implementation of the desired changes and, ultimately, an impact on the organization or its environment.

Siler-Wells (1987) conceptualizes policy development in a similar fashion, involving five consecutive stages: The process begins with a problem or need; policy, involving goals and aims, is formed to address the problem; following policy formation, strategic planning for implementation is undertaken which translates the goals and intent of the policy into a formula for action; the formula for action is put into practice through the policy implementation step, thereby achieving the final step, a solution to the problem.

It should be noted that these descriptions of the policy process have been questioned. Lindblom (1986:21), for instance, suggests that despite the immediate appeal of problem-solving formulas, "the formula is unacceptable and is not practised in public policy-making". He argues that the requirements that goals and strategies be agreed upon may be paralyzing; besides which, ends are more often found that fit the means than are means selected as appropriate to ends. Lindblom concludes by advocating an opportunistic approach in the pursuit of healthy public policies, hoping that agreement on healthy policies would be accepted on almost any terms on which they become available.

Ziglio (1987a), based on Etzioni (1967), Lindblom (1968) and others, reduces the above perspectives to three: the rational-deductive, the incrementalism and the mixed-scanning approaches. "In a rational-deductive

approach, a policy is structured in strategic terms, as involving a series of sequential steps worked out to attain a given objective" (Ziglio, 1987a:13). The emphasis typically is on the rationality of the process, the logical sequence of steps and the objective evaluation of the alternatives making full use of available scientific knowledge. Ziglio argues, however, that this approach can only be smoothly implemented by avoiding value questions and judgments about priorities, that it has been politically naive and utopian, and that it has not lived up to expectations.

Dumoulin (1985) explains the present disarray of health policy as the fault of an unworkable health planning model which is based on a rational pattern of decision-making and organization. Measures to improve health that fall outside the purview of Ministries of Health are not accessible by such a model. In the implementation of Health for All, for instance, he argues the problem is not so much one of further developing services as of transforming the underlying logic of the existing system. Such transformation is beyond the scope of rational planning: "A rational framework of analysis which ignores conflicts, interpersonal and power relations is completely cut off from the reality of decision-making structures and therefore can have no influence over it" (Dumoulin, 1985:202).

The critique of the rational-deductive model has been raised especially by supporters of the **second approach identified by Ziglio, incrementalism**. Lindblom, discussed earlier, is the most quoted critic. Given the limitations of human intellectual capacity, the inability to secure comprehensive knowledge and the neglect of the political context in the rational-deductive approach, incrementalism advocates 'muddling through' on the basis of value judgments of knowledgeable individuals or groups about policies and on their use of power and political skill to achieve mutual agreements. Hunter (1980) accepts that incrementalism is a plausible account of much policy-making but argues that it does not explain why some processes are more incremental than others. Nor, Hunter says, does it recognize that much in government is not incremental in appearance or in consequence. Incremental decision making, however, is seen by Ziglio as remedial, geared to the alleviation of current social imperfections, and capable of producing only marginal changes, if any. He suggests that it will tend to reinforce inertia and discourage innovation.

This view is confirmed by DeSario (1982), who argues that the past forty years of health care policy in the United States have been based on an incrementalist approach. Policies there have changed in response to social and economic contingencies, but DeSario contends that the most significant result is the existence of a large amount of program inertia in the health system as a whole. Program development under incrementalism "has deprived society of real-

izing the potential benefits of planning; instead, because of the deficiencies of incrementalism, it has imposed staggering social and economic costs" (DeSario, 1982:173). DeSario (1982:176) appears to favour "rational and strategic calculations toward an ultimate objective" within a centralized, integrated process of policy coordination and development. Unfortunately, this position may be subject to the same critique of the rational-deductive model cited above and may contradict the commitment to public participation that is a putative hallmark of healthy public policy.

The **third approach identified by Ziglio is mixed-scanning**, which attempts to overcome the shortcomings of the other two. It rejects the pure version of the rational-deductive approach because complete knowledge is unavailable and all possible consequences of a decision cannot be foreseen. The incrementalist approach is rejected on the basis of its shortsightedness. While accumulation of small changes could lead to significant change, incrementalism provides no guidance for such an accumulation. Mixed-scanning, therefore, advocates that fundamental decisions be taken by exploring the main alternatives available in view of policy goals and that incremental decisions be made, as rationally as possible, within the context of the fundamental decisions. Ziglio suggests, however, that this approach in practice may turn out to be "just as utopian as rational-deductive models and just as lethargic as muddling through" (Ziglio, 1987a:24).

Healthy public policy can be seen as a complex process in a changing social, economic and political environment. It must confront the power of vested interests while remaining committed to public participation, and it must resolve the contradiction between effective coordination and the decentralization that wide participation would entail. To this end, Ziglio (1987a) concludes that none of the three traditional approaches is adequate. Uncertainty, however, may require more planning rather than its abandonment. Of the three approaches, then, Ziglio recommends a mixed-scanning approach for healthy public policy.

Policy Design

While healthy public policy may require deliberate steps toward a long-range goal, policy-making in general has been seen as a trial and error process characterized by almost random interventions. Furthermore, policy analysis has favoured evaluation of the consequences rather than creation of specific alternatives (Linder and Peters, 1984).

Nagel (1984) writes in considerable detail on cost/benefit analysis, the measurement of equity, the weighing of goals and the selection of means for achieving them. A wealth of expertise exists in these traditional approaches. Nonetheless, the common pattern of policy designing, in the United States at

least, has been described as "routine and analogous", that is, as reformulating similar proposals within an issue area that is well established on the government's agenda and treating new problems on the basis of what was done in developing similar proposals in the past (Ingraham, 1987). "The imagery is normally that of considered choice between (sic) a number of alternatives based on a well-defined set of goals ... this model says nothing about the generation or crafting of alternatives" (Dryzek, 1983:346).

Recently, the focus of policy analysis has shifted to reflect growth in theoretical knowledge and in response to changing perspectives about the locus of major substantive problems. Ingraham (1987:625) notes that the analysis of policy design is a relatively new focus in public policy studies, yet as the formative first step of the policy process, it shapes that process in important ways. She defines **policy design as a process in which causal links between problem and solution are systematically explored** ... it does suggest that analytical attention will be directed to cause and effect at an early point in formulation activities, and that it be informed and guided by a broad explanatory framework.

Dryzek (1983:346), on the other hand, calls policy design "a somewhat elusive beast". He develops different design approaches that vary according to the complexity and uncertainty of the circumstances in which policy decisions must be made.

Common to these authors is their concern with bringing theory to policy-making, with understanding the characteristics of policy itself, and also the characteristics of the policy process (Linder and Peters, 1984). To this end, all three authors cited here contribute suggestions for improving policy design. Ingraham introduces eight variables to be considered in policy design, including problem solubility, goal consensus, the diversity of stakeholders and the resources available for policy. Linder and Peters suggest that policy problems might be characterized by such attributes as scale, certainty and independence rather than being categorized nominally by the name of a 'policy area' or a particular instrument. Dryzek considers the 'design of a design process', describing a hierarchy of levels at which policy design is increasingly required but is progressively less feasible.

Dryzek strikes at the central irony of policy design raised by the other authors: that policy design is most required under conditions of complexity and uncertainty, but that under such conditions, causal relations can be only tenuously identified, making policy design least feasible. We have observed that complexity and uncertainty are alleged to characterize the environment in which healthy public policy will be implemented. Policy design recognizes that some parts of a policy will be more easily controlled than others and are, therefore, more amenable to design. Healthy public policy might be scrutinized in just this way.

Problem Identification

While policy design has been identified as a formative first step in the policy process, none of the articles referred to thus far addresses the question of how a problem becomes identified as a policy issue in the first place. Nagel (1984) locates the sources of goals and policies in four main possibilities: (1) authority (persons, books, articles or other reliable sources of information); (2) statistical or observational analysis; (3) deduction, drawing conclusions from premises established from authority, observation and/or intuition; and (4) sensitivity analysis, which appears to be no more than sophisticated guessing. The latter, especially, seems to be the type of policy analysis with which the proponents of policy design have taken issue.

The influence of public opinion on problem identification is not easy to assess, even with respect to such a major issue as smoking control (Calnan, 1984). Some studies (Blum, 1983) suggest that organized groups of workers, for instance, can have an important effect, while other studies (Cox, 1983) suggest that demands of such groups are relatively minor in comparison to the impact of reform interests and the activities of civil servants.

Ham (1985) points to a growing body of work suggesting that political demands do not arise autonomously in the community but are manufactured by political leaders. "Through the manipulation of language and the creation of crises, the authorities may impose their own definitions of problems and help to frame the political agenda" (Ham, 1985:82). Cox (1983) and Lindblom (1986), on the other hand, stress human fallibility in arguing that policy-makers are more likely to misperceive problems, given the available evidence, than to operate from any Machiavellian intent. Calnan (1984:287), also, points out that "... there is no evidence to say whether politicians' beliefs about the state of 'public opinion' actually reflect what the electorate really feels".

Dror (1986:148) describes both problem definition (diagnostics) and agenda-setting as crucial to policy-making, but claims that both suffer from inherent incapacities and little investigation: "Diagnostics, as a policy-making facet, involves perception and initial explanation ... of relevant realities, their meanings and alternative futures." Dror (1986:148) argues that "Serious diagnostics distortions are very hard to repair once accepted as postulated reality, as policy assumptions and as policy-making starting lines."

To understand how a problem becomes defined as a policy issue requires attention to agenda-setting, which is the process of how issues are included and how priorities get established in policy-making.

Agenda setting allocates attention, as one of the scarcest policy making resources ... agenda priorities shape consideration of problems and their resolution ... problem formulation,

as often inherent in agenda setting, predetermines decisions, such as through reverting thinking to explicitly mentioned terms (Dror, 1986:153).

Unfortunately, Dror concludes that less is known about agenda-setting than other features of policy-making. He does suggest some possible issues affecting agenda setting, such as the 'politics of the day' driving out more basic issues, mass media influences, the delay of controversial and unpleasant items and the personal idiosyncracies of senior decision makers and their advisors. These features of actual agenda setting contravene such requisites of high quality policy-making as the timing of decisions, the need for multiple, open-ended problem formulations, and some correlation between agenda items and the main objective problems facing a policy.

RECONCEPTUALIZING HEALTH POLICY

The discussion to this point has been a general one concerning factors in and perspectives on the policy process. Consideration was given to three approaches to policy-making, to the importance of policy design and the difficulties of agenda-setting. It was suggested that healthy public policy-making could benefit from a mixed-scanning approach and explicit attention to policy design. The theoretical problem of agenda-setting is still outstanding but, judging from the currency of healthy public policy, the practical problems may have been partially overcome. Having raised some generic issues concerning the policy process, the discussion turns to several features peculiar to healthy public policy: its scope, the environment in which it is undertaken, and some implications of its participative nature.

From Health Policy to Healthy Public Policy

The assumption in the literature on health policy per se is that health policy is but one version of policy in general, such that the processes involved are transferable from one to the other. Health is a special case, of course, with its own set of actors and interests and its own domain of action.

From the perspective of healthy public policy, one of the shortcomings of health policy has been its entrapment in health care system policy, in turn dominated by medical care policy. Health has become equivalent to 'equal access to medicine' (Wildavsky, 1979:286). As noted earlier, Hancock (1982) was one of the first to coin the phrase 'healthy public policy', but also to contrast it to the conception of public health policy as 'sick care policy', sick care being that at which medicine excels. This shift from health policy to the notion of healthy public policy introduces another dimension to

policy discussions, that of an overarching, perhaps integrating, framework in which policies across all sectors are seen as affecting health.

Health, however, is not the first domain to have been considered deserving of an expanded conceptualization for policy purposes. Gil (1981:45) critiques the restrictive notion of social policy that conceptualizes it as "a reactive, ameliorative system for dealing with supposedly transitional short-comings of the 'self-regulating free-enterprise economy'". This critique is similar to that noted earlier by Hancock (1982), to the effect that health care policy is really the same thing as medical care policy. The point here is that social policy and health policy have both been narrowly conceived.

Gil (1981:46) suggests a model in which the domain of social policy includes all policies designed to regulate intra-societal relationships and the quality of life or level of well-being in a society. Economic measures are therefore not viewed as a separate policy domain but as an important means for realizing the objectives of social policy.

According to the World Health Organization (*Vienna Dialogue*, 1987:1), "the best health promotion policy is a good social policy". Health and social policy have been longstanding kindred spirits, and the kind of model of social policy suggested by Gil may be instructive in thinking about the new magnitude of health policy required by healthy public policy.

Stewart (1984a) describes a project undertaken by Environment Canada in which the relationship between economic factors and the environment was investigated. Part of the initiative for the project emerged from the relative status of Environment Canada as poor cousin to Finance and Energy, Mines and Resources, and the consequent difficulty it experienced in realizing its mandate to provide good environmental management. The result, for Stewart at least, was a fundamental reconceptualization of economics and public affairs, so as to see human affairs as an element in the context of the environment (Stewart, 1984b). In the course of the project, the role and mandate of Environment Canada and its location within the policy process also were fundamentally questioned. Stewart argues that a Copernican revolution is required in the perception of our situation and the management of our daily affairs. The economy needs to be situated in the context of the environmental universe, a reversal of the present relationship.

Brewer (1987) extends this discussion in a manner which begins to integrate policy analysis, environmental science or ecology, and public health. The policy sciences, as he calls them, and ecology, share some unusual characteristics. Both run counter to prevailing disciplinary and professional norms of fragmentation and specialization. They are both problem-oriented, they employ multiple methods

and they share a concern for both part and whole of events within given contexts. Brewer's arguments are evocative of Milio's (1985b) notion of the ecology of policy, suggesting a fruitful conceptual hybrid is possible between policy, science and ecology.

The purpose here is to acknowledge the new order of magnitude for 'health policy' demanded by healthy public policy and to provide examples of comparable conceptual and organizational re-examinations from other domains. These examples suggest that environmental science/ecology and policy studies as a field in its own right, are domains that could prove instructive for the study of healthy public policy.

The Healthy Public Policy Environment

The environment or context in which healthy public policy will have to be realized has been called post-industrial. Kickbusch (1986) argues that inherited structures do not fit the present realities and will not lead us safely into the future. A global health care crisis exists, she argues, and is characteristic of the situation in which traditional skills, roles and organizational mechanisms are inappropriate to the challenges at hand.

Schon (1971) drew early attention to what he considered to be an unprecedented and accelerating rate of change in modern industrial societies. While such a characterization can be challenged and may rest on stereotypical views of earlier societies as changeless, Schon nevertheless argues that present levels of social change may be approaching some kind of threshold, beyond which adaptation becomes increasingly difficult: "...while technological change has been continuing exponentially for the last two hundred years, it has now reached a level of pervasiveness and frequency uniquely threatening to the stable state" (Schon, 1971:27).

Khakee and Dahlgren (1986), based on case studies of the role of values in the planning process, contribute an analysis of the current environment noting the emergence of a dimension of values in addition to the traditional left-right continuum. They see this new values dimension as resulting from contemporary social movements such as feminism, environmentalism and the peace movement. One newly emergent value cluster is characterized by a concern that power be decentralized to and within the community, that the community increase its dependence on its own resources, and that quality of life and personal achievement be considered important. These values appear to underlie present discussions of healthy public policy. However, community self-sufficiency to the point of full independence is rejected as a viable value by some advocates of healthy public policy (Health for All Ontario, 1987) who argue that one aspect of community strength is the ability to access external resources which promote health.

The most salient finding of Khakee and Dahlgren (1986:193) was the differences in values between

planners and decision-makers on the one hand and citizens on the other:

...our studies confirm that the planners and decision makers seem to have been less affected by the new set of values which have developed, especially among the younger generation, in Sweden and other industrial countries. This new set of values ... is considered by the power elite as temporary, unrealistic and idealistic.

This value discrepancy, the authors observe, complicates the planning process.

Internationally, high levels of unemployment, large public and national debts in most western economies, stock market fluctuations and other economic changes are symptomatic of a global economic crisis in the eyes of some observers (Gough, 1979; Navarro, 1982; O'Connor, 1986). Most developed societies, Block and Hirschhorn (1979:363) argue, "face a transition from an industrial society, organized around the provision of services and advanced technologies that release labour from direct production". They contend that this transition creates a profound social crisis which has involved the restructuring of the welfare state, characterized by cuts in social expenditure, subsidization of the private sector and privatization of services (see also Navarro, 1982). If this is so, it may account for support of traditional, individualistic, health promotion approaches which emphasize individual rather than social or state responsibility for health (Smith, 1986).

Partly in response to economic constraints in the public sector in Sweden where the health care system has been the pride and linch-pin of the "welfare state," there has been a recent growth of the private health care market (Rosenthal, 1986). In the United States, France, England and Quebec, pressures of cost containment have led to renewed attention to issues of health promotion but, it has been argued (Kimberly, 1984 and Rodwin, 1984), it has been easier to place the burden of responsibility on individuals and to wage moral crusades against individual behaviours potentially damaging to health than to assume collective responsibility for prevention.

The consequences of such social changes, as well as of increasing environmental degradation, for health policy and for healthy public policy-making is at issue. For example, evidence suggesting that unemployment is associated with health risks suggests that health policy-makers must be concerned with economic policy. As Mustard (1987:472) has observed, "...one wonders how much communication exists between those concerned with our health and social problems and those concerned with our economic future".

Proponents of healthy public policy do not share common theoretical paradigms regarding the role of the state; nor can it be said that their assumptions about the role of the state are clear. Interest group

theory, which assumes a pluralistic model of the political process (Cox, 1983) contrasts with political-economy approaches (e.g. Navarro, 1987), and there are a host of alternatives to these two major approaches. Clarifying the assumptions of such models is a necessary step to undertaking healthy public policy research: To evaluate policy problems in the future

... it is essential to have a clear understanding of these competing perspectives [on the role of the state] if only to discern how the choice and formulation of health policies reflects political beliefs about the proper role of the state in society (Rodwin, 1984:52).

The environment in which healthy public policy is to be implemented, then, is characterized by complexity and instability, exemplified by value shifts and changes in the role of the state about which much is speculated but little is precisely known. Research efforts in healthy public policy require the explication and application of competing models of the relationship between the state, interest groups and the people to each other and to the health domain. While research in the Canadian context is sorely needed here, comparative research is also recommended.

Participation

Enhancing public participation is one of the guiding principles of healthy public policy (Healthy Public Policy Subplenary Report, 1987), but just what kind of public participation is called for is not clear. The Alma Ata declaration was unequivocal in linking primary health care to full participation of individuals and families in the community, stating that people have the right and duty to participate in the planning and implementation of their health care. Vuori (1984), however, states that in Europe, as in other developed countries, there is no need for participation in the sense of grass roots contributions to the establishment of health services; rather, people need the opportunity to participate in the existing processes of decision-making concerning health care.

Yet participation has many forms. Arnstein (1969) describes a ladder of participation which extends from non-participation through tokenism to citizen power, but then defines true citizen participation as the redistribution of power that enables have-not citizens to be included, for instance, in determining how tax resources are allocated, how information is shared and how goals and policies are set. For Arnstein, the redistribution of power is fundamental; unfortunately, how that redistribution is to occur is never articulated.

The issue of participation is a classic concern of political science, as are the problems of representation and decentralization (Bjorkman, 1985). All of these are relevant to the development of healthy public policy. Vuori (1984) poses the question, Who participates in What and How and Why?

The literature on participation consistently points to a relationship between the extent to which an individual participates and variables such as educational attainment, occupational status and family income. Men have been found to participate more than women, and long-time residents have been found to be more inclined to participate than new ones (Edwards and White, 1980). Edwards and White (1980) and Parker (1983), for example, note problems of method and measurement in the literature, but the relationships mentioned above appear to be conceptually well entrenched. It has always been difficult to ensure participation of the have-nots.

The experience with mandated participation in the United States has not been encouraging. Specified levels of citizen participation have not been achieved and/or such participation has been relegated to minor or peripheral issues. Mandated community organizations have neither increased the role of typically excluded populations nor have they been sources of change for public policy (Gittel, 1983).

Internationally, the health sector includes a wealth of experience relevant to participation. Studies of Health Systems Agencies in the United States and international comparisons among different arrangements for governing the health sector, however, suggest that participation of consumers in health planning and policy-making has had little impact on health system reform. A numerical majority of consumers on governing boards does not guarantee lay control of decision-making, as consumers tend to defer judgment to providers (Riddick, Cordes, Eisele, and Montgomery, 1984). Planners may emphasize technical planning values antithetical to consumer participation and perceive consumers to delay action and increase costs. Consumer board members are not always representative of their area's population or accountable to major constituency groups. The dominance of physicians and hospital administrators the most active, best organized and most influential participants remains (Checkoway, O'Rourke and Bull, 1984), and consumers have not necessarily developed alternative views on health policy issues. According to Fontana (1986:554):

...it is not enough to provide the trapping of participation and assume the development of health policy reforms. The existing planning system in the U.S. clearly faces a danger of encouraging the further entrenchment of private and professional interests in health policies (Fontana, 1986:554).

Bjorkman (1985:415) provides a succinct summary based on comparative field data:

...policy options selected by professional elites are legitimated by arrangements for citizen participation. Yet when citizens sit on planning boards, operational committees and

health councils, lay participants are rarely active. The agenda is set by the chairperson in consultation with the professional staff of experts and administrators. Due to time constraints and background knowledge, lay participants have little basis on which to discuss technical matters, so they usually accept staff recommendations. The professional staff often resolve their own conflicts before meetings, so that a united front is presented to the board. Any lay participant who frequently dissents from the recommendations of the professionals is soon labeled a "troublemaker" or an "ego-tripper" and is subsequently ignored.

Bjorkman also observed that no matter what the organizational arrangements or modes of financing, physicians dominated decision-making in the health sector. Despite Tierney's (1987) contention that the number of organized interests in health policy-making is no longer restricted to the inner circle of the medical-industrial complex, Bjorkman sees a disproportionate representation of health care providers or suppliers of one sort or another. This is not unexpected since those whose livelihoods are affected will be highly motivated to protect their interests (Bruton, 1980).

Interest groups appear to be accepted as functionally necessary and useful in the political arena (Pross, 1975). The introduction of other sector and ordinarily excluded interests into health policy discussions, however, acutely raises a number of issues regarding the appropriate participation of interest groups in democratic policy-making. The legitimacy of interest group representation in political decision-making itself may presume that direct citizen participation is infeasible; yet healthy public policy rhetoric may sometimes confuse the two. Direct participation has remained elusive and is perhaps inoperative in the face of modern political realities.

Issues are complex, fragmented and persistent. Those who have more invested will, over time, care most—invest most—in the relevant politics. Over time, producer interests tend to win. Hospitals seeking to expand or pharmaceutical firms marketing new drugs will attend public meetings, regardless of inconvenient hours, with lawyers, experts and charts. The public will not do so regularly. They have their own livelihoods to attend Those with more at stake care more, commit more resources to policy debates. Many successful policy reforms have emerged in the past decade; few of them are rooted in the Rousseauian ideal of mass citizen participation (Morone, 1984:246).

If interest group representation rather than mass participation is going to be accepted into healthy public policy, then various questions may be raised.

What group should be allowed to share in decision-making if the process is to be democratic? What is a genuine interest and who should decide this? Mulgan (1984) concludes that the appropriate democratic constituency for any issue is those people whose interests are affected by it; these interests may be community-wide as well as personal or sectional. To be consistent with democratic pluralism, Mulgan would include differences in the weighing of interests. This proportionate equality "... requires that individuals be treated differently from one another depending on the degree of immediacy of their interests" (Mulgan, 1984:121). This raises a major problem of assessing the differences among interests. For example, based on this view, professionals might argue that they are legitimately more central than other groups in policy-making because of their career interests. Many interests cannot be translated into financial or quantifiable terms. "What price can be put, say, on the public's interest in health or an unpolluted environment?" (Mulgan, 1984:123).

Mulgan ultimately suggests that some form of "corporatist pluralism" is necessary, in which power is shared among different interest groups whose legitimacy is publicly determined and guaranteed by the government.

Van Til (1984) examines several scenarios of citizen participation in the future and concludes that corporatism could provide a model for democratic participation.

Corporatism, after all, is a theory that weights societal interests by the value to the collectivity. If compensatory policy is to be implemented, corporatism, uniquely among major political theories, permits the rational adjustment of political weights. Affirmative action, representation of the poor, black power all are values that can well be accommodated by corporative structures and patterns (Van Til, 1984:322).

Morone argues that the ultimate promise of citizen action is the introduction of voices that are not likely to be heard in traditional policy institutions. Political history appears to confirm that "...in conceptual, political, or organizational terms, the major achievement of citizen action is empowering groups organized around special interests...." (Morone, 1984:251).

Corporatist models will therefore have to accommodate calls for broadly based participation, including participation of weakly organized segments of society. For example, Milio (1985a:) argues that "... in the process of developing health promoting policy, the strength of powerful groups must be balanced by ensuring the participatory capacity of weak groups, those whose voices often are not heard".

The literature suggests that to strengthen citizen participation, a distinctive power base must be developed, perhaps from an identifiable local constituency or from

representation of relevant grass roots community organizations (Fontana, 1986). In this view, measures need to be taken to make citizens more confident in their own abilities and more comfortable with decision-making responsibilities (Riddick et al., 1984). Citizens "should develop personal skills, organizational capabilities and lobbying strategies to build effective citizen groups to institutionalize themselves into the policy-making process" (Checkoway, O'Rourke and Bull, 1984:307). Government should provide general support for self-initiated citizen organizations in the form of small, direct grants based on the proven ability of an organization to get citizen support for its programs (Gittell, 1983). These recommendations are similar to Milio's (1987b) notion of "capacity building", that is, building the capacity of citizen organizations to participate in policy-making and of government to incorporate them.

Tierney (1987) contends that interest group participation in the United States has not yet paralyzed health policy as it has in other areas of national politics and policy-making. He argues that a democracy in which citizen demands are mediated by vigorously contending organized interests is less likely to be characterized by turbulence, disorder and extremism because the process mobilizes those who are already committed to procedural democracy. The probability of political polarization is also reduced by the likelihood that antagonists on one issue may cooperate on another.

The possible shortcomings of pluralism should not be forgotten, however:

Representational systems are political instruments rather than neutral attributes. They structure the political process—some groups and interests are advantaged, others enfeebled. Political outcomes are biased by the parties that are injected or insulated from political frays (Morone, 1984:248).

Another critique of pluralism is found in analyses of interest group activity within the health sector. Alford's (1975) conceptualization of three major structural interests, the professional monopolists, the corporate rationalizers and the equal health advocates, has been put to good use in studies of the policy process in the capitalist state (Ham and Hill, 1984), of health policy in Britain (Ham, 1985), and of primary health care in Sweden (Hessler and Twaddle, 1986). In this perspective, structural interests form the context in which other interest group activity takes place. Interest group conflict may occur, but it never changes the dominant pattern of power relationships that is the fundamental structure of the system. Conflict may occur between groups of doctors, for instance, but can leave unchallenged the principle of professional monopoly and dominance (Ham, 1985).

There exists also a more general critique of the "corporatist tenor of our time" (Hill, 1983:18). It is argued

that the core institutions of the political system have lost meaning for citizens. The system excludes the expression of concerns that are not amenable to strategic calculation, and this plus the decline of motivating world views, the spread of pluralist mechanisms of interest group aggregation and the technocratic rationalization of the system itself, developments apparently greeted with favour by Tierney (1987) foster cynicism, corporatism and egoistic concern for self. The formally democratic system is claimed to be unable to generate even a fiction of a general political will or to provide collective identities.

Reform from above is criticized as crisis management which furthers administrative and capitalist penetration of social life in the name of social rights and protection (Cohen, 1983). Social control is the dark side of this kind of interventionist state (Hill, 1983). Yet the alternative of increasing citizen participation through decentralization of power may prevent the solution of problems which originate nationally or for which local fiscal resources are inadequate (Hill, 1983). Smith (1986), for instance, argues that if the state withdraws service provision, local groups will not necessarily provide an equitable and progressive system of care. Furthermore, Stein (1986) argues that building citizen participation around common interests will not guarantee actual participation.

Social movements, on the other hand, may provide collective identities, democratic forms of association and solidarities (Cohen, 1983). Siler-Wells (1987) sees evidence of grass roots support for the basic values of a positive-health policy in activities such as the quality of worklife movement and the adult and community education movements. If healthy public policies are "to recognize and respond to society's expressed desire for change [in such a way as to] support and potentiate these trends" (Siler-Wells, 1987:831), policy-makers may need to consider the means by which social movements can be fostered. Great social movements labour, populist, civil rights, women's captured the interest and imagination of large numbers of people by affirming their identity and providing an experience of communal solidarity as well as material benefits (Stein, 1986).

The features of healthy public policy reviewed in this section may exacerbate an already difficult process. The complications of ordinary policy-making are said to exceed our mental capacity (Lindblom, 1986) but healthy public policy may involve yet another order of conceptualization. Scanning the environment of healthy public policy raises questions about the disposition of the social climate to healthy public policy interventions (Milio, 1987b). While the record of public participation in policy-making does not inspire confidence, indications of an "overwhelming level of interest in the [Healthy Cities] project" (Ashton, 1986:22), may give evidence of an incipient movement which could garner the public awareness and support required to establish healthy public policy.

According to Stein (1986:112), "The development of organizational culture and identity should be placed alongside more strategic considerations in community organizing". This suggests that attention should be paid to vision and values in healthy public policy. We now turn to those issues.

VISION, VALUES AND GOALS

Vision in Healthy Public Policy

Lee and Mills (1982), reflecting on Lalonde's (1974) health field concept, conclude that approaching health policy and planning in its terms would require such a radical reorientation of outlook that most health service practitioners and governments would prefer to leave it as a utopian ideal. Dror (1986), however, argues that the dimension of vision, values and goals is essential for an adequate treatment of policy-making, especially under conditions of adversity. Blum (1981) insists that for planning purposes, idealism is justified, that a vision of a desired future is a fundamental impetus to action.

Public health is held to always have had a "social vision". Vision has been identified as a fundamental requirement for effective health promotion policy (Epp, 1986:253).

The envisioned health future is also, in large measure, the envisioned social future. Duhl (1986a:34) points out that, given the percentage of Gross National Product devoted to health care and the extent to which health care concerns must be related to those of the broader society, "to some extent, therefore, health planning has become societal planning".

A rationale for this emphasis can be found in normative planning (Jackson, 1981) and in the type of planning advocated for unstable and complex conditions or "turbulent environments" (Emery and Trist, 1973). This is also called "proactive planning" (Emery, 1985). Ziglio (1986a) argues that acknowledging uncertainty does not preclude developing a normative vision of the future to orient health-related policies. Under conditions of turbulence, no stable reference point exists against which to judge the appropriateness of planning decisions. A vision of a desired future, be it Utopia or Health for All Ontario (1987), articulates the basic ideals and values that people hold: "Typically, these are not just goals or even the more important goals. They are ideals like health and happiness that, at best, one can approach stochastically" (Williams, 1982:17). Changes in immediate goals and objectives are possible without losing sight of desired, more distant values (Williams, 1982).

Proactive planning as described by Williams (1982) may therefore be an appropriate mixed-scanning means to healthy public policy ends. Healthy public policy rests explicitly on a shared vision. Kickbusch (1986) states that this shared vision involves intersectoral action. Proactive planning incorporates the

perspectives of various players into a shared portrait more representative of the totality than any individual vision and illustrates the mutual dependence of the players. Participation, another key element of the new vision of health policy (Kickbusch, 1986), has also been identified as a necessary and valuable component of effective planning (Addis, 1985; Blum, 1981).

For Hancock (1982), the future society is a "Conserver society". For Ehrenreich (1982), it is a "healing society", and for McKnight (1987), it is a vision of "community". These respective visions are largely consistent with one another and with the principles of healthy public policy and health promotion (Sub-plenary Report on Healthy Public Policy, 1987; *Health Promotion: Concept and Principles*, 1986). They all envisage a socio-ecological approach to health, equity, broad participation and strengthened communities. (See also the CPHA Report, *Strengthening Community Health Means Strengthening Communities*, 1987).

Despite their widespread advocacy, the theoretical and empirical evidence for the efficacy of vision statements is not clear. One argument of those who believe in the importance of vision statements is that, having shared in the development of visions, the players will be more likely to cooperate in implementation than if a program were imposed (Addis, 1985). Another argument is consonant with the tenets of health promotion itself: enabling people to increase control over and to improve their health, is beneficial (*Health Promotion: Concept and Principles*, 1986). Vision workshops have been undertaken as the initial foundation for the Healthy Toronto 2000 Project, resulting in a *Healthy Toronto 2000* discussion paper (1987; Hancock, 1987).

Dror (1986), however, dismisses Williams' (1982) proposals for vision statements as utopian. He contends that vision is essential to improved policy-making but also dangerous. The vision, Dror argues, must be realistic, not "visionary" or having a tendency to dogma. That Williams requires shared visions to be developed does not necessarily circumvent this criticism; moreover, shared visions are not always arrived at democratically but are often imposed by higher authority.

Furthermore, the connection between visioning and subsequent planning steps is not straightforward. While some kind of "visioning" seems to be an appropriate first step for a mixed scanning approach to policy-making, it may be that, to be shared, "vision statements" must be so abstract as to be largely meaningless. The report of the Ontario Health Review Panel, *Toward a Shared Direction for Health in Ontario* (1987:i) noted with concern that even "well-founded recommendations made by credible groups over a period of fifteen years have rarely been translated into action".

Examined in the light of sociological theory, the notion that a shared vision is a necessary prerequisite to coordinated action is highly compatible with a

structural-functionalist theoretical paradigm. It places a great emphasis on consensus as the foundation of patterned social behaviour. However, structural-functionalist assumptions are challenged by conflict theorists who see conflict, power relationships and negotiation as more accurately characterizing social life. The notion of vision as a key component of healthy public policy should be examined closely in light of different theoretical paradigms in the social sciences.

Values

Meijer (1984) identifies two directions in recent planning developments. One involves increased attention to decision-making procedures. Meijer concludes that health care systems in many countries are unlikely to have or to get the decision-making structure that such a planning approach requires. The second direction is one that pays more attention to the development of values and objectives in health care. The healthy public policy planning that has been undertaken to date appears to be strongly weighted in this direction.

Blumstein and Zubkoff (1979) argue that empirical observations alone are insufficient for identifying problems government should address. A conceptual framework, informed by value judgments where appropriate, is needed to determine which facts present problems and which problems should be addressed by government policy. Duhl (1986a) more specifically insists that values need to be understood and incorporated as primary and endemic aspects of policy-making.

Discussion of healthy public policy has been explicit in its value commitments to equity, participation and collective responsibility (Epp, 1986; Healthy Public Policy Sublenary Report, 1987; *Health for All Ontario*, 1987; *Health Promotion Matters in Ontario*, 1987). In addition, sustaining health itself is a basic value articulated in this literature (Milio, 1985).

The discussion of values in the healthy public policy literature may be viewed as conceptually underdeveloped, if judged against the standards of contemporary social science theory. What is not yet spelled out, nor empirically examined, is the relationship between values, norms and action, and the role which value consensus or descensus might play in the formulation and implementation of healthy public policy.

Linder and Peters (1984) distinguish between **fundamental** values, which are typically avoided for policy purposes because of the potential conflicts that differences could create, and **instrumental** values, which play a prominent policy role in problem recognition and definition. Policy designers need attend only to the latter values, they say. On the other hand, Blum (1981:8) contends that the inevitable diversities of value positions may be of the "greatest utility", and that "...participation in planning should teach all of us more about our own values as we struggle to reconcile them with the values of others".

The policy values of effectiveness and efficiency are longstanding concerns of traditional policy analysis (Nagel, 1984), as are questions of the potential conflict between equality, equity and freedom. The Panel on Health Goals for Ontario (*Health for All Ontario*, 1987) argues that equity, not equality, is the issue for healthy public policy. Weale (1983) concludes that the protection of both equality and freedom is compatible with some form of the welfare state.

Conceptually, equity itself, to which healthy public policies should be directed (Milio, 1986b), is ambiguous. There is a tendency in social scientific and political discourse to slip between 'equity' and 'equality'. The importance of conceptual clarity is underscored by the strength of the debate between advocates of equity and advocates of equality. On one hand, Bjorkman suggests that:

Perhaps the tendency is due to a feeling among the electorate and among many intellectuals as well that 'equity' sounds nicer, more fair and less threatening than 'equality'. Pleas for equitable policies are the calling cards of moderates, of 'reasonable men' who would work within the system, while demands for equality conjure up images of the French Revolution and its violent aftermath or even more contemporary visions of a totalitarian society that levels all before it (Bjorkman, 1985a:18).

On the other hand, advocates for equity, such as the Panel on Health Goals for Ontario, argue that acting on the basis of a goal of equity may require unequal treatment, such as allocation of disproportionate resources to high-need or deprived target areas. For example, fairness (equity) may require spending disproportionate amounts of money and effort to compensate for previous neglect in the area of Canadian native people's health.

Research should clarify such issues as whether the equity criterion in fact rules out some of the measures that advocates of healthy public policy, certainly of health promotion, would propose. Kemm (1985), for instance, chronicles some ethical dimensions of food policy and raises issues with respect to the application of policy measures across the population. To be effective, a policy may have to be applied to the whole population, but how is the question of the balance between benefit and harm to be resolved if a minority is inconvenienced? "The difficulty is increased because those who benefit are generally unidentifiable and unaware that they have benefitted while those who are harmed are all too conscious of the fact and are identifiable" (Kemm, 1985:291). This difficulty also adumbrates some of the research problems encountered in the evaluation of the health effects of policy interventions.

Goals

Goals are the ends to which public policy is directed, but there remains some confusion and lack of terminological agreement about the distinction

between goals and objectives. Nutt (1984) notes that, in the private sector, goals are treated as subservient to objectives, goals having properties that can be easily measured whereas objectives are broad, mission statements. The opposite, he says, is true for the public sector, where a goal is a broad statement of intent to be achieved over the long term, whereas objectives identify the shorter-term intent of projects initiated to realize goals.

Quinn (1977) states that employment of broad, general goals is the hallmark of successful executives of large companies. They refrain from announcing precise, integrated packages of goals for a variety of reasons, such as the centralizing tendency of top-down goal announcements, the opposition that explicitly stated goals can mobilize, and the rigidity that top-down goal setting can engender. General goals, on the other hand, are said to promote cohesion because consensus will be more easily achieved at a broad level of discussion, and because goals provide a reference point for people to identify with something larger than themselves. Specific goals, however, can precipitate change if introduced at the proper moment and they can help to signal a major change from the past.

Health goals per se have been defined in different ways. Reeves, Bergwall and Woodside (1984) view goals as statements of desired conditions expressed as quantifiable, although timeless, aspirations, both technically and financially achievable and responsive to community ideals. *Health for All Ontario* (1987), however, uses goals to refer to broad statements of desired change that are not necessarily attainable, with the term 'objectives' used to refer to a more specific statement in a measurable form. This document also defines 'targets' as referring to specific amounts and timelines of desired change. In the view of the Panel on Health Goals for Ontario, the healthy public policy process proceeds from values through goals to objectives and targets, with each stage representing a greater degree of specificity.

Goals are common features of policy analysis used as criteria for evaluating alternative public policies, often stated in terms of efficiency and effectiveness, but also equity. As discussed earlier, equity is a frequently voiced value or goal in the healthy public policy endeavour. Nagel (1984) devotes a chapter to equity as a policy goal, discussing the meaning and measurement of equity, its trade-offs with other goals such as efficiency and freedom, and its use as a criterion in choosing among policies. The value of equity also establishes a goal of equity. Nagel argues that equity is worth promoting, as least as a deterrent to antisocial or anti-establishment reactions from those who are treated inequitably. "By definition, equity as a minimum constraint has to be met before other goals can be maximized or achieved" (Nagel, 1984:105).

Yet Linder and Peters (1984) state that goals are the least well understood component of policy-making and that value-laden goals such as equity complicate the

process further. Blumstein and Zubkoff (1979) suggest that caution should be exercised with respect to the adoption by government of substantive health policy targets (by which they mean objectives) in the pursuit of equity. Research initiatives are needed, however, to identify the conditions under which values, goals and objectives aid or hinder the process of healthy public policy implementation.

SUMMARY

This chapter presented an overview of the preliminary steps of the policy process, then discussed the features of healthy public policy that may complicate them. In the final section of the chapter, recent efforts to incorporate these features in the policy process were discussed.

Three approaches to public policy-making have been identified: the rational-deductive approach, incrementalism, and the mixed-scanning approach. It was suggested that a mixed-scanning approach is the most appropriate for the development of healthy public policy. Within this approach, attention should be paid to policy design, and to the exploration of causal links between problem and solution, guided by a broad explanatory framework.

Examples of expanded conceptual frameworks exist in social policy, ecology and policy studies that might instruct the formation of healthy public policy frameworks. Whatever form they take, such frameworks need to incorporate the environment in which healthy public policy is to be undertaken. The social climate may well determine the feasibility of healthy public policy interventions, so must be included conceptually from the beginning. The nature of public participation in this policy-making also must be clarified. While some references to public participation in healthy public policy discussions appear to imply a form of corporatism, these need to be examined for their consistency with healthy public policy values. While various social movements may provide lessons for the mobilization of public sentiment, harnessing this popular energy is not a straightforward task.

Policy design appears to be most required under conditions of uncertainty which make it the most difficult to implement. Healthy public policy embodies an appreciation that policies across all sectors impact on health.

Proponents of healthy public policy differ theoretically as to their model of the relationship between interest groups and the state. A major research challenge is to clarify the assumptions of various models of the state, and the implications of these assumptions for questions of public participation in the policy process.

Attempts to harness the energy of shared values through 'visioning' processes and proactive planning have been made in the interest of creating a healthful future, but shared values may be a tenuous found-

ation for healthy public policy, especially in light of conflicting interests. Furthermore, while the rhetoric of healthy public policy makes explicit the value commitment to equity, the traditional trade-off between it and other policy values such as efficiency has not been resolved. The notion that a shared vision facilitates the coordination of healthy public policy is not grounded theoretically or supported empirically at this stage of research.

Goal-setting is one component of the policy process that has been realized in Ontario at least, but the follow-up that would translate such goals into action is not necessarily assured. This problem of implementation is addressed in the next chapter.

REFERENCES

- Addiss, Susan S. Setting goals and priorities: 1984 presidential address. *American Journal of Public Health*, 75(11), 1985:1276-1280.
- Alford, Robert. *Health Care Politics: Ideological and Interest Group Barriers to Reform*. Chicago: University of Chicago Press, 1975.
- Arnstein, Sherry R. A ladder of citizen participation. *AIP Journal*, July 1969:216-224.
- Ashton, John. Healthy Cities A World Health Organization Project. Unpublished manuscript. 1986.
- Bjorkman, James Warner. Equity and social policy: Conceptual ambiguity in welfare criteria. *Comparative Politics*, 17, 1985a:16-32.
- Bjorkman, James Warner. Who governs the health sector? Comparative European and American experiences with representation, participation and decentralization. *Comparative Politics*, July 1985b:399-420.
- Block, Fred and Hirschorn, Larry. New productive forces and the contradictions of contemporary capitalism: A post-industrial perspective. *Theory and Society*, 7(Jan/March), 1979:363-395.
- Blum, Henrik L. *Planning for Health: Generics for the Eighties*. New York: Human Sciences Press, 1981.
- Blum, Linda M. Politics and policy-making: The comparative worth debate. *Berkeley Journal of Sociology*, XXVIII: 1983.
- Blumstein, James F. and Zubkoff, Michael. Public choice in health: Problems, politics and perspective on formulating national health policy. *Journal of Health Politics, Policy and Law*, 4(3), 1979:382-413.
- Brewer, Garry D. Policy sciences, the environment and public health. Paper prepared for a Symposium of Health Public Policy, Yale University, October 5-6, 1987.
- Bruton, M.J. Public participation, local planning and conflicts of interest. *Policy and Politics*, 8(4), 1980:423-442.
- Calnan, Michael. The politics of health: The case of smoking control. *Journal of Social Policy*, 13(3), 1984:279-296.
- Checkoway, Barry, O'Rourke, Thomas W. and Bull, David. Correlates of consumer participation in health planning agencies: Findings and implications from a national survey. *Policy Studies Review*, 3(2), 1984:296-310.
- Cohen, Jean L. Rethinking social movements. *Berkeley Journal of Sociology*, XXVIII:97-113.
- Cox, Andrew. On the role of the state in urban policy-making: The case of inner-city and dispersal policies in Britain. In Valdo Pons and Ray Francis (eds.), *Urban Social Research: Problems and Prospects*. Sociological Review Monograph 30. London: Routledge and Kegan Paul, 1983:31-65.
- Crichton, Anne. *Health Policy-making: Fundamental Issues in the United States, Canada, Great Britain and Australia*. Ann Arbor, Michigan: Health Administration Press, 1981.
- DeSario, Jack. Demise of health planning in the United States: The politics of incremental health policy formation. *Journal of Public Health Policy*, June 1982:164-177.
- Draper, Ron. Informal lecture given at Health and Welfare Canada, September 22, 1987a.
- Dror, Yehezkel. *Design for Policy Sciences*. New York: American Elsevier Publishing Company Inc., 1971.
- Dror, Yehezkel. *Policymaking Under Adversity*. New Brunswick: Transaction Books, 1986.
- Dryzek, John S. Don't toss coins in garbage cans: A prologue to policy design. *Journal of Public Policy*, 3(4), 1983:345-368.
- Duhl, Leonard J. *Health Planning and Social Change*. New York: Human Sciences Press, Inc., 1986a.
- Dumoulin, Jerome. Representations used for health planning: Naivety and crisis in the concepts and methods. *Health Policy*, 5, 1985:199-205.
- Edwards, John N. and White, Randall P. Predictors of social participation: Apparent or real? *Journal of Voluntary Action Research*, 9(1-4), 1980:60-73.
- Ehrenreich, John. Toward a healing society. In Ellen Frankel Paul and Philip A. Russo, Jr., (eds.), *Public Policy: Issues, Analysis and Ideology*. Chatham, New Jersey: Chatham House Publishers, Inc., 1982:186-197.

- Emery, F.E. and Trist, E.L. *Towards a Social Ecology*. New York: Plenum Publishing, 1973.
- Emery, Fred. Public policies for healthy workplaces. *Canadian Journal of Public Health*, 77, Supplement 1, May/June 1985:46-50.
- Epp, Jake. National strategies for health promotion. *Canadian Journal of Public Health*, 77, July/Aug 1986:243-247.
- Etzioni, Amitai. Mixed-Scanning: A "Third" Approach to Decision-Making. *Public Administration Review*, 27 (Dec.), 1967:385-92.
- Fontana, Leonard. Political ideology and local health planning in the United States. *Human Relations*, 39(6), 1986:541-556.
- Gil, David G. A systematic approach to social policy analysis. In Anne Crichton (ed.), *Health Policy-making: Fundamental Issues in the United States, Canada, Great Britain and Australia*. Ann Arbor, Michigan: Health Administration Press, 1981:45-55.
- Gittell, Marilyn. The consequences of mandating citizen participation. *Policy Studies Review*, 3(1), 1983:90-95.
- Gough, Ian. *The Political Economy of the Welfare State*. London: The MacMillan Press, 1979.
- Ham, Christopher. *Health Policy in Britain*. London: MacMillan Publishers, 1985.
- Ham, Christopher and Hill, Michael. *The Policy Process in the Modern Capitalist State*. Sussex: Wheatsheaf Books, 1984.
- Hambleton, Robin. Planning systems and policy implementation. *Journal of Public Policy*, 3(4), 1983:397-418.
- Hancock, Trevor. Beyond health care: Creating a healthy future. *The Futurist*, XVI(4), 1982:4-13.
- Hancock, Trevor. Healthy Toronto 2000: A vision of a healthy city. Unpublished manuscript. 1987b.
- Health for All Ontario*. Report of the Panel on Health Goals for Ontario, August 1987.
- Health Promotion: Concept and Principles, in Action, A Policy Framework*. Unpublished discussion document. Copenhagen: World Health Organization, Regional Office for Europe, 1986.
- Health Promotion Matters in Ontario*. Report of the Minister's Advisory Group on Health Promotion, 1987.
- Healthy Public Policy Subplenary Report. *Health Promotion*, 1(4), 1987:447-448.
- Healthy Toronto 2000*. Toronto: Healthy Toronto 2000 Subcommittee, Board of Health, August 1987.
- Hessler, Richard M. and Twaddle Andrew C. Power and change: Primary health care at the crossroads in Sweden. *Human Organizations*, 45(2), 1986:134-147.
- Hill, Robert C. Market, state and community: National urban policy in the 1980's. *Urban Affairs Quarterly*, 19(1), 1983:5-20.
- Hunter, David J. *Coping with Uncertainty: Policy and Politics in the National Health Service*. Chichester: Research Studies Press, 1980.
- Ingraham, Patricia W. Toward more systematic consideration of policy design. *Policy Studies Journal*, 15(4), 1987:611-628.
- Jackson, Suzanne Fraser. Planning for health in a changing society. A study of the relationship between a changing social paradigm, turbulence, non-conventional health care practices and planning. Unpublished doctoral dissertation. University of Waterloo, 1981.
- Kemm, J.R. The ethics of food policy. *Community Medicine*, 7, 1985:289-294.
- Khakee, Abdul and Dahlgren, Lars. Values in futures studies and long-term planning: Two Swedish case studies. *Futures*, 18(1), 1986:52-67.
- Kickbusch, Ilona. Health promotion: A global perspective. *Canadian Journal of Public Health*, 77, Sept/Oct 1986:321-326.
- Kimberly, John R. The future of health policy: Constraints, controls and choices. In Jean de Kervasdoué, John R. Kimberly, and Victor G. Rodwin (eds.), *The End of an Illusion: The Future of Health Policy in Western Industrialized Nations*. Berkeley: University of California Press, 1984.
- Lalonde, Marc. *A New Perspective on the Health of Canadians*. Ottawa: Health and Welfare Canada, 1974.
- Lee, Kenneth and Mills, Anne. *Policy-making and Planning in the Health Sector*. London: Croom Helm, 1982.
- Lindblom, C.E. How to think about the policy-making process. Unpublished work. Not to be cited without permission. 1986.
- Lindblom, Charles. *The Policy-Making Process*. Englewood Cliffs, N.J.: Prentice-Hall, 1968.
- Linder, Stephen H. and Peters, B. Guy. From social theory to policy design. *Journal of Public Policy*, 4(3), 1984:237-259.
- McKnight, John. Regenerating community. *Social Policy*, Winter 1987:54-58.
- Meijer, A.W.M. Some aspects of alternative approaches to planning. In Charles O. Panneborg, Albert van der Werff, Gary B. Hirsch and Keith Barnard (eds.), *Reorienting Health Services: Application of a Systems Approach*. New York: Plenum Press, 1984:69-89.
- Milio, Nancy. Commentary: Creating a healthful future. *Community Health Studies*, IX(3), 1985a.

Systems Approach. New York: Plenum Press, 1984:69-89.

Milio, Nancy. Commentary: Creating a healthful future. *Community Health Studies*, IX(3), 1985a.

Milio, Nancy. Healthy nations: Creating a new ecology of public policy for health. *Canadian Journal of Public Health*, 76, Supplement 1, May/June 1985b:79-87.

Milio, Nancy. Building healthy public policies: Focus for a new public health. Paper prepared for presentation at *An International Conference on Health Promotion: The Move Towards a New Public Health*, November 17-21, 1986b, Ottawa, Canada.

Milio, Nancy. Personal Interview, October 28, 1987b.

Morone, James A. The citizen role in health politics: Democratic wishes and sensible reforms. In Theodor J. Litman and Leonard S. Robins (eds.), *Health Politics and Policy*. New York: John Wiley and Sons, 1984:243-257.

Mulgan, R.C. Who should have much say about what? Some problems of pluralist democracy. *Political Science*, 36(2), 1984:112-124.

Mustard, J. Fraser. "Achieving Health for All": Implications for Canadian health and social policies. *Canadian Medical Association Journal*, 136(March 1), 1987:471-473.

Nagel, Stuart S. *Public Policy: Goals, Means and Methods*. New York: St. Martin's Press, 1984.

Navarro, Vincente. The crisis of the international capitalist order and its implications for the welfare state. *International Journal of Health Services*, 12(2), 1982:169-190.

Navarro, Vincente. Federal health policies in the United States: An alternative explanation. *The Milbank Quarterly*, 65(1), 1987:81-111.

Nutt, Paul C. *Planning Methods for Health and Related Organizations*. New York: John Wiley & Sons, 1984.

O'Connor, James. *The Fiscal Crisis of the State*. London: St. James Press, 1986.

Parker, Robert Nash. Measuring social participation. *American Sociological Review*, 48(6), 1983:864-873.

Pinder, Lavada. Healthy public policy in Canada. Presentation at *Other Voices*, The Canadian Institute of Planners National Conference, July 5-8, 1987.

Pross, Paul. *Pressure Group Behaviour in Canadian Politics*. 1975.

Quinn, James Brian. Strategic goals: Process and politics. *Sloan Management Review*, Fall 1977:21-37.

Reeves, Philip N., Bergwall, David F. and Woodside, Nina B. *Introduction to Health Planning*. Arlington, Virginia: Information Resource Press, 1984.

Riddick, Carol C., Cordes, Sam, Eisele, Tura and Montgomery, Allison. The health planning process:

Are consumers really in control? *Health Policy*, 4, 1984:117-127.

Rodwin, Victor G. Perspectives on the state: Implications for health policy. In Jean de Kervasdoué, John R. Kimberly and Victor G. Rodwin (eds.), *The End of an Illusion: The Future of Health Policy in Western Industrialized Nations*. Berkeley: University of California Press, 1984:35-55.

Rosenthal, Marilyn M. Beyond equity: Swedish health policy and the private sector. *The Milbank Quarterly*, 64(4), 1986:592-621.

Schon, Donald A. *Beyond the Stable State*. New York: W.W. Norton and Company, 1971.

Siler-Wells, Gail. An implementation model for health system reform. *Social Science and Medicine*, 24(10), 1987:821-832.

Smith, Christopher J. Equity in the distribution of health and welfare services: Can we rely on the state to reverse the 'inverse care law'? *Social Science and Medicine*, 23(10), 1986:1067-1078.

Stein, Arlene. Between organizations and movement: ACORN and the Alinsky model of community organizing. *Berkeley Journal of Sociology*, XXXI, 1986:93-115.

Stewart, Gail Ward. The leading question: A paper related to a project on economics and environment. Draft paper, property of author, 141 Cameron Street, Ottawa, Ontario, K1S 0X2, 1984a.

Stewart, Gail Ward. Gaining perspective on environmental issues: A fresh look at familiar problems. *Focus*, 10(1), 1984b:14-16.

Strengthening Community Health Means Strengthening Communities. Draft report, Canadian Public Health Association, Ottawa, Ontario, 1987.

Tierney, John T. Organized interests in health politics and policy-making. *Medical Care Review*, 44(1), 1987:89-118.

Toward a Shared Direction for Health in Ontario. Report of the Ontario Health Review Panel, 1987.

Van Til, Jan. Citizen participation in the future. *Policy Studies Review*, 3(2), 1984:312-322.

Vienna Dialogue on "Health Policy and Health Promotion Towards a New Conception of Public Health". Copenhagen: World Health Organization, Regional Office for Europe. Unpublished document ICP/HSR 623, 1987.

Vurori, Hannu. Overview Community participation in primary health care: A means or an end? *Public Health Review*, 12, 1984:331-339.

Weale, Albert. Issues of value and principle in social policy. In Martin Loney, David Boswell and John Clarke (eds.), *Social Policy and Social Welfare*. Milton Keynes: Open University Press, 1983:104-116.

Wildavsky, Aaron. *Speaking Truth to Power: The Art and Craft of Policy Analysis*. Boston: Little, Brown and Company, 1979.

Williams, Trevor A. *Learning to Manage our Futures" The Participative Redesign of Societies in Turbulent Transition*. New York: John Wiley and Sons, 1982.

Ziglio, Erio. Uncertainties and dilemmas in future health policy scenarios: Some cautionary issues. *Futures Research Quarterly*, 2(4), 1986a:5-16.

Ziglio, Erio. Policy-making and planning in conditions of uncertainty: Theoretical considerations for health promotion policy. Draft working paper No. 7, Research Unit in Health and Behavioural Change, Edinburgh, Scotland, 1987a.

Chapter Four

THE PROCESS OF IMPLEMENTING HEALTHY PUBLIC POLICY

Healthy public policy has been identified as a primary strategy for health system reform (Epp, 1986; *Health for All Ontario*, 1987). The previous chapter has sketched some of the dimensions to be considered in developing healthy public policy. Work remains to be done along any of the dimensions discussed here, but the tenor of the field is now not "what shall be done" but "how to do it".

Following Siler-Wells (1987), this chapter locates planning for healthy public policy in an environment characterized by change. From a discussion of change, the notions of normative and strategic planning are introduced, followed by a discussion of planning for implementation per se. Suggested conditions for effective implementation, and directions for research, emerge from a review of this literature. The final section refers briefly to program design and policy instruments.

The notions of policy-making and planning often appear to be used interchangeably, as in "strategic policy making or planning" (Solesbury, 1981:419). Yet Nutt (1984) points out that it is not clear whether policy is created by planning or is merely assessed by an evaluative process, implying that planning is evaluative and that policy formation is outside the realm of the planning process. Reeves, Bergwall and Woodside (1984), however, state that policies contribute to the efficiency of the planning process. It is not always certain whether planning serves policy or policy serves planning.

Recognition of pressing issues in health has been followed in most countries by the establishment of planning machinery (Blum, 1981). Standing planning bodies are often set up to assist the policy-makers in analyzing issues and formulating policy proposals. Blum (1981:242) strongly encourages "all health planning bodies to undertake formulation of new policy proposals as well as engineering their acceptance and full implementation". In this sense, public policy-making can be seen as the implementation of planned proposals into a "formally acknowledged, standing, constant guide, usually in the form of legislation" (Blum, 1981:225). Nutt (1984:7) sees such planning as desirable because "...well-posed options ... can sharpen the debate and expose vested in-

terests, stimulate comment, and reduce caprice. Clearly this is a role for planning in policy making". Reeves, Bergwall and Woodside (1984), paraphrasing Sir Geoffrey Vickers, state that policies are operational statements of society's values. Planning, then, may be considered to operationalize policies, by attempting to carry them out and/or by working to formulate policy in the first place.

Others, however, see formal policy planning as unwise or even potentially evil (Lindholm, 1965 and Nutt, 1984). They argue that public policy should evolve through political debate and democratic process a point similar to Linder and Peters' call (1984) for attention to goal-setting and clarification through the political process.

Meijer (1984) discusses a variety of approaches to planning, using a topology similar to that of Ziglio (1987a), described earlier, for policy. Meijer refers to the rational-comprehensive, the disjointed-incremental, and the mixed-scanning types of planning. In addition, he identifies five levels of planning: (1) normative, which addresses the question "why?" and is concerned with ideals and values; (2) institutional, which asks "who?" and is concerned with competencies; (3) strategic, which asks "how?" and is concerned with objectives; (4) structural, which asks "where?" and is concerned with means and structures; and (5) operational, which asks "what?" and is concerned with tasks. Meijer extends Ziglio's critique of "rational approaches" to policy-making to planning, and, like Ziglio, notes problems of complexity and uncertainty. Planning is concerned with the reduction of uncertainty and with the creation of deliberate social change to build a desired future (Blum, 1981). The pressures for planning thus appear to be greater in unstable than in stable environments (Blum, 1981; Ziglio, 1986a).

Planning for Health Policy Change

For all its emphasis on normative planning steps and envisioning a desired future, the field of healthy public policy may be on the verge of the "implementation conundrum a framework of goals and plans but little in the way of achieved outcomes" (Siler-Wells, 1987:823). Siler-Wells (1987) contends that the implementation conundrum consists of three

barriers: a universal fear of change; inadequately developed social change technologies; and the failure to plan for implementation. She describes a two-stage process of strategic planning for implementation to move through the conundrum. The first stage involves isolating the degree and type of changes sought by a policy; the second stage develops strategies to facilitate the desired changes. To the extent that planning is aimed at creating desired social change (Blum, 1981), Siler-Wells' model is valuable because it emphasizes the change dimensions.

Blum (1981) notes two schools of thought with respect to the origin of social change, one of which assumes that change starts with individuals, the second of which assumes that change is precipitated by environmental forces. Duhl (1986a) describes social change and personal change as inextricably linked and cites a role for the health planner as "the facilitator or educator of a society's holistic learning, helping people to face the issues of health" (Duhl, 1986a:66). Other authors extend the notion of social learning in social change (Morgan and Ramirez, 1983:23), arguing that action learning is an appropriate means by which "to set a basis for personal and collective self-transformation".

Whole system change or transformation, which healthy public policy may entail, is a prevalent theme in modern organization theory. Gemmill and Smith (1985), for instance, identify Lewin (1951) as an original contributor to social change theory, but they elaborate Lewin's notions in terms of a dissipative structure model which incorporates disorder, uncertainty, and complexity. Gemmill and Smith identify four elements of system transformation: disequilibrium—misalignment between the system and its environment; symmetry breaking—the breakdown of existing functional relationships; experimentation—the generation of new forms around which the system might reorganize; and reformulation—the selection of a new form for reorganization. They conclude with several propositions that relate to the likelihood of a system transforming itself or collapsing.

The notions of adaptive social learning and transformation in turbulent environments come together under the normative learning model of planning, characteristics of which have been alluded to in the previous chapter. Mechanisms to re-examine basic norms and values are an integral part of the model, as are a normative vision and guiding framework. The process based on this model is intended to be flexible and participative, capable of rapid adjustment to keep in step with the pace of change (Jackson, 1981).

Drawing on Jackson (1981), Ziglio (1987a:45) suggests six principles that may be relevant to policy-making and planning in health promotion under conditions of change:

1. Increase policy-diversifying mechanisms.

2. Make cooperation and collaboration the primary mediating social relationship instead of competition.
3. Use a future orientation to guide change in a purposeful way.
4. Stop being concerned with predictable control through domination of the entire process, but look for ways of influencing the direction of change for unpredictable social processes.
5. Seek interactive learning processes.
6. Give more decision-making responsibilities to individuals, small locally based groups or local community.

Whether they stem from conscious decisions to engage in active adaptive responses to health system turbulence, some of these suggestions are already apparent in the rhetoric of healthy public policy.

On the other hand, the change literature referred to here seems naive. Despite acknowledging the truism that both individuals and environmental forces function in social change, power relationships and the political economic context of change seem to be only marginally considered.

Wallerstein (1984), for instance, locates change within capitalist economic cycles. He speaks of social tensions that eventually grow sufficiently acute that workers become more militant and the middle strata lose their typical moderation: "In the short run, reforms are never the gift of the privileged to the dispossessed, but their fearful response to and retreat before the organized anger of the dispossessed" (Wallerstein, 1984:583).

Waitzkin discusses health policy and social change through a comparative history of Chile and Cuba. Both countries sought to implement health system reform; Waitzkin contends that Cuba was successful whereas Chile was not.

The comparative histories of Chile and Cuba ... reveal the vulnerability of incremental reforms. Dominant groups in society [in this case the medical profession in particular] do not surrender power peacefully, and the tenuous character of reform cannot be wished away. In this light, it appears that social transformation is a precondition for popular control and lasting reform of health services More than ever before, it is clear that the struggle toward a humane health-care system cannot succeed without a concomitant struggle toward basic change in the social order (Waitzkin, 1983:246).

Wallerstein (1984) contends that an apparently unsuccessful or palliating short-term change may nonetheless result in dramatic long-term change. In the short run, to ignore reforms and innovation is to be doomed to social irrelevancy. The point here, however, is simply to raise to the forefront the issues of power and political economic context that the previous discussion of social change had neglected.

It may be that good planning would confront power issues, for example, in its environmental scan and

assessment of alternatives. The critique of systems approaches to understanding social change, therefore, accepts the importance of planning but suggests that it include among its armamentarium elements of what Segall (1983) calls socialist health theory. That theory stresses the importance of social factors in the causation of diseases, especially stemming from the social class structure; it calls attention to social factors affecting the capacity of peoples to undertake health-related activities; and it emphasizes the economic, political and professional control of health care services. These dimensions are not uniquely identified by socialist or materialist theory but are also available to planning for healthy public policy in the ecological view of health.

Strategic Planning

Having identified the dimensions of change that influence healthy public policy reform, strategies to facilitate reform can be investigated. Solesbury (1981) traces the concept of strategy to its nineteenth-century military origins, where it referred to the means of bringing forces into contact with the enemy. Strategy is distinguished from tactics, which are the means to defeat the enemy in battle, and both differ from logistics, which refers to the movement and supply in support of strategy or tactics. Solesbury cites the mixed-scanning approach to decision-making described previously as one that incorporates strategic concepts: since all possible strategies cannot be anticipated, a full exploration of goals and alternatives is made, after which fundamental decisions are taken which set the basic directions. Incremental decisions are taken within those parameters until danger is foreseen or changing conditions suggest a re-examination of the strategy.

Solesbury notes that different concepts of strategy have emerged over the years but most include: notions of acting purposively to define a direction for an entire organization; focusing on the interaction between the organization and its environment; recognizing uncertainty internal and external to the organization; establishing longer term views in which to consider the implications of day-to-day decisions; considering a wide range of alternative objectives and actions; and creating decision-making priorities.

Strategic planning has been used in the private sector since the late nineteen sixties (Porter, 1987). It has developed a sophisticated theoretical base, drawing on sociological concepts and recent work on social change to improve planning effectiveness and practical competencies (Mason, 1968; Morgan, 1983). However, Lamb (1987) notes that private sector experience is not directly applicable to the public sector because of differences in environment and organization, because of the non-profit orientation of the public sector, and because of different 'target markets'. Public organizations have less autonomy and flexibility than private ones, for example, but face less competition. They are subject to political influence and

"have much more comprehensive interrelationships with the general public than do private firms" (Lamb, 1987:60). Lamb concludes that public organization problems may require public organization solutions.

There is no shortage of interest in the public sector in developing strategies for health. Angus and Manga (1986) suggest that the time is right to develop national health strategies in Canada based on Lalonde's *A New Perspective on the Health of Canadians* (1974). They include in their article a rational planning model to structure the overall planning process as well as suggestions for research to facilitate it. The Canadian Public Health Association (*A Proposal to Establish Health Objectives and Strategies for Canada*, 1985) drafted a proposal to undertake a process in which to develop health objectives and identify strategies to address major Canadian health issues. The Federal Minister of Health (Epp, 1986) has identified six strategies for health promotion, and three major health reports in Ontario all have suggested strategies for health and health promotion, with specific recommendations for action (*Health for All Ontario*, 1987; *Toward a Shared Direction for Health in Ontario*, 1987; *Health Promotion Matters in Ontario*, 1987). Healthy public policy itself, variously known in these three documents as integrated government policy, public policy for health, or intersectoral policies for health promotion, is considered to be a fundamental strategy to promote health and is integral to health system reform. Healthy public policy in Canada may not be so much on the verge of the implementation conundrum as in the midst of it.

PLANNING FOR IMPLEMENTATION

Siler-Wells (1987) identifies the failure to plan for implementation as an important barrier to health system reform. This failure may not be for want of trying: policy planning systems proliferated during the 1970s (Hambleton, 1983), and the previous section chronicled strategic planning initiatives suggested by a number of Canadian groups.

A common assessment, however, is that rational planning has failed everywhere it has been tried (Wildavsky, 1979). Solesbury (1981) presents three case studies in which strategic planning was undertaken, including one on the National Health Service in Britain, and concludes on the basis of these that strategic planning in practice has been disappointing. The structures, procedures and staffing established for the planning process have not always come up with recognizably strategic policies; and even where the policies have been defined, with formal commitment from public authorities, day-to-day decision making has frequently disregarded them.

The strategic initiatives referred to in the previous sections could be reviewed for their merit in terms of

their ability to incorporate the dimensions of healthy public policy discussed in this review. They may provide a strong foundation for action.

An awareness has emerged that the processes of implementation should be more closely considered in planning public policy (Hambleton, 1983). Typically, planning for implementation per se has not occurred beyond the allocation of a budget and a time limit for the enactment of legislation (Siler-Weils, 1987). The implementation phase is that stage at which policy is shaped into action (Lee and Mills, 1982), and through which congruence can be obtained between plans and results (Wittrock and DeLeon, 1986).

Wittrock and DeLeon (1986:45) also identify implementation as an area of policy-making that "seems most alluringly amenable to formal planning"; unfortunately, these hopes seem also to have been overly optimistic. There is a segment of the implementation literature, in fact, that Linder and Peters (1987) have termed the 'horrors of war approach', which tends to lament the impossibility of perfect administration. In this literature, the concept of implementation is considered troublesome, characterized by

...complexity, confusion of the borderline between politics and administration, sustained patterns of conflict between policy-makers and implementors and within each group, goal redefinition, and policy evolution (Lane, 1986:474).

Linder and Peters contend that this literature appears to assume that policy-making problems would be solved if only bureaucrats and implementing organizations could be coerced into doing what they should. Mayntz (1979:633) refers to cases of "spectacular" policy failure, as in the 'war on poverty' in the United States, that drew attention to the role of administrative organizations in the success or failure of a policy. Spitzer (1987) refers to policy itself as state-inspired coercion and Solesbury (1981) suggests several steps to ensure higher congruence between plans and implementation, all of which involve gaining advantage over implementors through control of information or other resources.

Linder and Peters (1987), however, argue that policy failure is not only the result of inadequate implementation. In the article cited above, Mayntz (1979) is sympathetic to the discretionary role played by public bureaucracies in policy implementation. Bureaucracies are not necessarily unchanging, but may evolve, for instance, under the demands of intersectoral policy-making (Roberts and Colvin, 1987). While the politics of policy may engender conflict between bureaucracies within central government, this departmentalism can be overridden if the governing party is firmly committed to a course of action (Baggot, 1986). Finally, Thompson (1984) contends that

the 'bureaucracy problem', while important, should not preclude attention to the external contingencies that shape implementation.

Another cause of policy failure is inadequate policy design, the creation of a program with little possibility of success. Design failures may stem from excessive ambition, such as some of the American anti-poverty legislation, or result from misunderstanding the nature of the problem. Robertson (1984) describes a version of reverse design failure with respect to two employment training programs in the United States. These programs apparently were legitimated on the premise that they would serve large segments of the American labour force, especially the most needy, but were in fact designed on the premise that they would serve employers. The 'privileged position of business' was a taken-for-granted design feature and implementors who were comfortable with the business-oriented approach of the programs were chosen. Robertson concludes that the programs were successful, as designed, in serving the labour needs of employers.

McKnight (1977) contends that professionalized services have been designed in the interests of the professionals rather than their clients. The apparent intransigence of clients who refuse to use these service products appropriately has reached such proportions that

we are now designing new systems that surround these individuals with professionally administered services This is usually called a "comprehensive, multidisciplinary, coordinated, interagency service system." It is the equivalent of institutionalization without walls or the design of an environment to create a totally dependent service system consumer (McKnight, 1987:55).

Fox (1986) suggests that the crises plaguing the American health care system actually are the unintended consequences of several generations of general consensus regarding the aims of the system.

These insights from McKnight and Fox call attention to Linder and Peters' (1987) third type of policy failure, that in which the policy per se may be considered a success. In this type, policy may be successfully implemented but the total social impact of the policy may be negative. As an example, they suggest programs that achieve their stated goals of making cash payments to certain classes of individuals, but under conditions of eligibility that debilitate family structure.

One more source of apparent failure is raised by Barrett and Hill (1984) in the form of symbolic policy-making. Politicians may wish to appear to be in favour of certain ideals or goals while actually doing nothing about them. Any system in which policy-making and implementation are clearly separated, either by a division between legislature and executive or between levels of government, provides

ample opportunity to promulgate symbolic policies while neglecting to provide commensurate resources for implementation.

'Top-Down' versus 'Bottom-Up' Approaches

In the policy process, implementation traditionally has been considered to be primarily administrative and distinct from policy formulation. Policy is the decision regarding what to do, implementation is getting it done. This distinction is retained in this review for purposes of exposition, but in practice it may be difficult to define where policy ends and implementation begins (Hambleton, 1983). Some authors regard the policy-making process as something which continues into the so-called implementation stage. Policies may evolve through this stage as conflicts unresolved during policy formulation continue to influence the actions undertaken and as the actual nature of the policy is negotiated between those seeking to put policy into effect and those upon whom action depends (Ham and Hill, 1984).

Implicit in the preceding paragraph are the two principal perspectives in the implementation literature, the top-down and the bottom-up perspectives. Sabatier (1986) reviews the implementation literature of the past fifteen years, comparing the relative strengths and weaknesses of these two approaches.

The essential ingredient of the **top-down approach** is that it starts with a policy decision, often a statute, made by central governmental officials. Sabatier and Mazmanian (1979) provide a paradigm case of recommendations for the accomplishment of policy objectives from this approach. Updated to 1986, Sabatier lists the six conditions thought to be sufficient and generally necessary for effective implementation:

1. Clear and consistent objectives.
 2. Adequate causal theory.
 3. Implementation process legally structured to enhance compliance by implementing officials and target groups.
 4. Committed and skillful implementing officials.
 5. Support of interest groups and sovereigns.
 6. Changes in socio-economic conditions which do not substantially undermine political support or causal theory
- (Sabatier, 1986:23).

The first three conditions can be incorporated into the initial policy decision, whereas the latter three are a function of subsequent political and economic pressure during the administrative process.

The **bottom-up approach**, on the other hand, is concerned with policy implementation as actually realized. It therefore emphasizes the discretion of the 'street level bureaucrats' on whom the responsibility for implementation of policy and programs rests (Wittrock and DeLeon, 1986). As opposed to the top-down focus on formal organizational hierarchies, communication

and control mechanisms (Barrett and Hill, 1984), policy is determined by explicit or implicit bargaining between policy formulators and the policy implementors from different organizations. Policies are not fully implemented by a single organization, then, but by an implementation structure or policy network of individuals within public and private organizations (Thrasher, 1983). The conditions for successful policy implementation under this approach are compatible with the needs of lower echelon officials. Linder and Peters (1987) state that such compatibility is almost certain anyway, given the bottom-up assumption that those officials will mold policy to suit themselves. Thrasher (1983), however, applies exchange theory to the problem of understanding the processes whereby policy networks are developed, maintained and adapted in the interests of being able to modify implementation structures to serve the policy-makers rather than the implementors.

Each of these perspectives has its shortcomings. Sabatier (1986) identifies four main criticisms of the top-down approach. Their fundamental flaw is that these models start from the perspective of central decision-makers, to the detriment of other actors. The framers of the policy decision are assumed to be the key actors while others are considered to be impediments to proper implementation.

A second criticism is that top-down models are difficult to use in situations involving numerous governmental directives and actors, none of them pre-eminent. This criticism may be especially salient for a multisectoral undertaking such as healthy public policy. Top-down models of implementation have little to say regarding the outcome of such complex situations except that any policy of interest probably will not be effectively implemented.

A third criticism is that top-down models ignore or underestimate the extent to which "street level bureaucrats" and target groups will employ strategies to circumvent central policy and/or divert it to their own purposes. A related point raised by Sabatier is that top-down models are likely to neglect many of the counterproductive effects of the policies chosen for analysis.

The fourth criticism argues that the distinction between policy formulation and implementation is misleading and/or useless. This point is the same as the argument that policy evolves and that it is a process only fully determined upon implementation. Sabatier contests this criticism on the grounds that the relative influence of elected officials and civil servants becomes difficult to distinguish. He also argues that the view of policy as a seamless web without decision points precludes both policy evaluation (because there is no policy to evaluate) and the analysis of policy change (because there is no defined policy at one point in time to compare to another defined policy at a second point in time).

A characteristic of the top-down approach is giving advice to top actors about how they should secure ef-

fective implementation. This prescriptive approach is said to embody two cherished values:

...a liberal-democratic view that policy should be made by the elected representatives of the people and implemented in a subordinate manner by public officials, and a view that rationality in public policy involves goal setting followed by activities in pursuit of those goals which may be systematically monitored (Ham and Hill, 1984:108).

The bottom-up perspective is not without its own problems. From the point of view of implementation research, Sabatier (1986) laments the methodological confusion that characterizes bottom-up studies. Several other problems in some respects parallel those of the top-down perspective. The power of those at the bottom is likely to be overestimated, while the power of other political actors is underestimated. An additional problem is that the present distribution of preferences and resources is frequently taken as given, without inquiring into the efforts of other actors to structure the rules of the game.

In this light it should be noted that, once in place, formal rules spawn the routines that comprise a key ingredient of health policy implementation. Standard operating procedures guide much implementation behaviour (Thompson, 1984). Barrett and Hill (1984), referring to literature on the British National Health Service, state that the very structure of the service protects the interests of the medical profession and ensures that it is involved in the policy-making process. Doctors, they speculate, could subvert the implementation process if necessary, but most of the time their built-in power obviates overt action.

In summary, both the top-down and bottom-up perspectives appear to neglect the underlying structure and the power context of implementation.

Sabatier (1986) criticizes the bottom-up approach also on the bases that present participation is given, without attention to previous efforts to affect participation rates, and that it fails to start from an explicit theory of factors affecting its subject of interest. Relying heavily on the perceptions and activities of participants in an implementation structure, it is their prisoner; it is unlikely to recognize indirect factors influencing participants' behaviour or even direct influences of which participants are not aware.

Linder and Peters (1987:463) are severely critical of the bottom-up approach: "This approach to implementation studies may have the greatest potential detrimental effect on the development of policy studies". The first problem arises if the descriptive generalizations about the determination of implementation from the periphery are accepted also as prescriptive statements: that the lower echelons should determine implementation. If that is the case, they say, then many ideas about policy control in democratic political systems must be questioned.

Sections of this review suggest that the discussion of healthy public policy warrants just this sort of questioning, although Linder and Peters in this case appear to be employing it rhetorically. There are indeed important questions about the degrees of centralization and decentralization appropriate in the policy process. Linder and Peters object that the view from the street, which may be characterized by prejudice, is not necessarily more valid than an overview from the top. A second danger they identify in relying on the bottom-up approach is that what can be done by existing organizations with minimal disruption may come to define what should be done.

Despite this attention to the distinctions between top-down and bottom-up approaches and the respective criticisms of each, recent literature on implementation reveals a convergence of views or a willingness to view the different perspectives as complementary rather than mutually exclusive (Wittrock and DeLeon, 1986). Lane (1986), for example, in a case study of the creation of Norrland University in Sweden, supports the bottom-up emphasis on the importance of the behaviour and motivation of the implementors, while clearly showing that policy enactment, an initiative from the top, was the starting point of the implementation process.

The complementarity of the two approaches has been incorporated into any number of frameworks (O'Toole, 1986), several of which will be consulted here to suggest factors to be considered in implementation.

Hambleton (1983) identifies five key factors which shape the implementation process: the policy message; the multiplicity of agents; the multiplicity of perspectives and ideologies; resources, and the politics of planning. The policy message is a concept that embraces both the substance of policy and the way it is communicated.

Rather than the clear, consistent objectives recommended by Sabatier and Mazmanian (1979), Hambleton recognizes that there are limits to the clarity of messages from the top. In some areas, clear performance indicators or targets will be difficult to identify. Policy ambiguity may also arise from uncertainty in the form of imperfect understanding of the policy issue or little control over implementors. Furthermore, ambiguity may be fostered deliberately to leave room to negotiate and manoeuvre. Thain (1987) recognizes the difficulty this poses for researchers who wish to evaluate or assess policy. However, Hambleton insists that a potential strength of policy ambiguity is that it leaves scope for learning and reformulation during implementation.

Sabatier (1986) concludes that his original emphasis on clear and consistent policy objectives was a mistake, that subsequent empirical work shows that most policies incorporate a multitude of partially conflicting objectives. To evaluate policy under these circumstances, he suggests that an 'acceptability space' can be identified, demarcated by the intersection of the range of acceptable values on each of the

evaluative dimensions involved. Intuitively, as well as for the reasons cited previously in this review, the importance of goals is hard to deny. The implementation literature, however, suggests that some ambiguity is acceptable, even useful.

Hambleton's second key factor shaping policy implementation is the difficulty of achieving coordination between a multiplicity of agents. Hambleton thinks coordination is impossible, but suggests that, on the evidence, two-and-one-half years for planning is required. Part of the explanation for this length of time relates to coordination and the need to take time to develop policies which have the support and, where possible, commitment of the various agencies responsible for implementation. This is more time than central government has tended to assume.

Sabatier (1986) found implementing agency support to be consistently critical to understanding program performance and in understanding the strategies of program proponents over time. Thain (1987) and Siler-Wells (1987) argue that the capacity of agencies to change is an important dimension to consider in assessing the feasibility of implementation.

Hambleton's third factor for analyzing implementation issues relates to the differing perspectives and ideologies different groups of actors bring to the implementation task. This factor essentially refers to actors' perceptions of the situation and their 'assumptive worlds'. Assumptive worlds are defined as the intellectual framework used by policy participants to cope with the events of everyday life by providing a map of social reality. Included on that map, for instance, are assumptions about the appropriate amount of state involvement, the degree of citizen consent required before policy is implemented, and what aspirations are feasible in a given policy area (Thain, 1987). Implementors may misunderstand or fail to execute a policy because they reject its goals, because the policy challenges the set of core beliefs an implementor holds and/or it is outside the realm of his assumptive world (Thrasher, 1983).

Resources constitute Hambleton's fourth factor central to the policy implementation process. Financial resources are especially important here, but Thain (1987) also includes constitutional, legal, political, informational, hierarchical and technological resources. Hambleton stresses that one should guard against the top-down assumption that an infusion of additional resources will, in itself, speed the implementation of policy. Hambleton's own experience, in fact, suggests that the pressure of programming resources, formulating finite programs with their detailed lists of projects to fit fixed budgets and time scales, significantly distracted attention away from analytical work that might secure necessary changes in ongoing policies. During an era of public expenditure restraint, however, the importance of resources is heightened.

Hambleton's final factor shaping policy implementation overlaps the previous ones. Hambleton calls it the politics of planning, referring to the conflict, negotiation, and compromise which occurs in implementation bargaining. Thain (1987) challenges the notion that consensus is necessary for successful implementation. Rather, conflict occurs at every stage of the policy process, is inevitable between actors with different interests and policy goals, and reflects the conflict endemic in society. From this point of view, the policy process can be seen as a negotiated order, the sum of the agreements and rules built up between actors. Barrett and Hill (1984) attend especially to bargaining in implementation. A crucial issue they identify in bargaining is the degree to which one group of actors is in a position to control, coerce or influence the behaviour of others, when conflict arises among them.

Hambleton's is one of a number of frameworks by which to consider the factors in policy implementation. It seems sufficiently generic to raise most of the issues likely to be encountered in the implementation of healthy public policy.

Laurence O'Toole (1986) has surveyed the same field in the interests of policy recommendations for multi-actor implementation. His article tabulates key variables from more than 100 studies, which makes it, especially in combination with Sabatier's (1986) paper, an excellent map of the implementation literature. Unfortunately, his assessment finds the field to be complex, with little cumulation or convergence. The few well-developed recommendations put forward by researchers for the use of policy-makers appear to be contradictory, although the impact of this discrepant advice cannot be judged due to the absence of research utilization studies.

Sabatier (1986) contends that the bottom-up approach has not developed enough of a substantive theory to be able to make predictions. The few recommendations O'Toole does identify, then, stem from the top-down approach and from a conventional wisdom that appears to run through the literature as proverbs. The following summary is provided:

To maximise the probability of implementation success, from the standpoint of the center, one should (1) design policies to keep the degree of behavioral change low...; (2) simplify the structure of implementation and minimize the number of actors...; (3) seek more consideration of the problems of implementation during the initial stages of policy formation...; and (4) take care to leave the responsibilities of implementation among units sympathetic to the policy.... (O'Toole, 1986:200).

Sabatier (1986) cites research suggesting that the probability of effective implementation of a reform

and the extent of envisaged departure from the status quo ante are not related inversely, but curvilinearly: too little change will not arouse interest, while comprehensive reform garners too much resistance to get started. "Those reforms ... which are ambitious enough to arouse commitment from proponents but rather limited in their effects on the entire system stand the best chance of success" (Sabatier, 1986: 29).

In contrast to O'Toole's recommendation to simplify, Bowen's (1982) work with probability analysis leads to increased optimism about the likelihood of successful implementation in multi-actor situations. Other research, involving regulatory policy, concludes that, under certain conditions, complexity may actually ease implementation by rendering multi-actor compliance more attractive. These conflicting pieces of evidence in particular may provide some hope for healthy public policy in the face of other components of conventional wisdom claiming that multisectoral problems are more difficult (Mayntz, 1983).

Considering implementation during initial stages of policy formulation, O'Toole cites research suggesting that, if such questions are raised, programmatic goals will be sacrificed to the demands of executing them. This is reminiscent of Linder and Peters' (1987) concern that what can happen becomes covert into what should happen. Finally, O'Toole presents cases in which the sympathy or opposition of key actors toward a policy appeared to determine very little during implementation.

O'Toole concludes that contradictory and counterintuitive advice is prevalent in the implementation literature, but does not despair of the fact. His review revealed implicit agreement on several clusters of variables deserving further investigation. The variables identified are policy characteristics, resources, implementation structure, implementor disposition, the implementor-client relationship, and timing. While not isomorphic with Hambleton's (1983) five factors, there is sufficient overlap to confirm the heuristic utility of the previous discussion to suggest studies of healthy public policy implementation.

PROGRAMS FOR HEALTHY PUBLIC POLICY

In addition to the policy implementation literature reviewed above, there is a literature which can inform policy operationalization through its consideration of program development. 'Program' and 'policy' seem to be used interchangeably, although programs can be usefully distinguished as "concrete legal and bureaucratic attempts to translate general policy intentions into specific government actions. They are means to the end of realizing larger if not necessarily

well-defined political goals and values" (Thain, 1987:68).

Mayntz (1983) discusses the importance of program design in reaching policy goals. Linder and Peters (1984, 1987) also emphasize design. Wolman (1981) develops thirty-eight hypotheses regarding the determinants of program success or failure which set an agenda for social science research, but which also could serve as checklist of factors to consider in program design.

Mayntz (1983) notes that different policy instruments may be appropriate for different programs, for instance, that incentives and persuasion are preferred where some voluntary effort is required by the members of the target group. Woodside's (1986) study of the influence of the type of instrument chosen in the policy-making process is an important Canadian contribution to the study of public policy.

This literature is referred to in passing to indicate further steps to be taken in the practical implementation of healthy public policy. Work on the influence of policy instruments in related areas, such as in prevention (see Barer, Evans, Stoddart, Labelle, and Fulton, 1984) is also relevant.

SUMMARY

Planning is central to the process of implementing healthy public policy. The changing conditions of the public policy environment increase uncertainty and thereby increase the importance of planning. Furthermore, the complexity of the healthy public policy domain (i.e. the number of players, its inter-sectoral and interjurisdictional nature, the presumed need for widespread participation) also heightens the need for planning both strategic planning and planning for implementation itself. Planning for implementation emerges as a particularly important but hitherto comparatively neglected area in the literature.

Both the legitimacy and the possibility of policy planning have been the subject of considerable debate. Planning is held to reduce uncertainty and to facilitate desired social change. However, it is unclear whether planning facilitates policy or the reverse.

Barriers which constitute an "implementation conundrum" include a universal fear of change, lack of well-developed social change technologies and failure to plan for implementation. To these, we add power relationships and the political-economic context of change.

Rational planning models have been judged inadequate to overcome these barriers, particularly because they neglect the implementation stage. Policy implementation may fail to realize formally stated goals but serve hidden, unintended or symbolic functions. The line between policy per se and implementation is not clearly drawn.

The dispute between proponents of 'top-down' and 'bottom-up' approaches to policy implementation seems now to have led to efforts at reconciliation. Effective implementation requires not only clear and consistent objec-

tives and the support of central authorities but also committed and skillful implementing officials and the support of interest groups. Moreover, it requires environmentally supportive socio-economic and political conditions which do not undermine public support. A major thrust of research in the coordination of healthy public policy initiatives must address the conditions under which varying degrees of centralization facilitate implementation. Related to concerns about centralization, the extent to which ambiguity, rather than clarity in the articulation of policy initiatives, facilitates implementation is a matter of some dispute.

Planning for implementation is a political process requiring resource allocation, negotiation and compromise. The extent to which consensus is a prerequisite for effective policy implementation is very much open to debate. Thus, little is known about the utility of goals, or 'vision' in facilitating implementation, even though these are intuitively attractive concepts promulgated by many in the healthy public policy field.

Two important, and highly similar, frameworks for policy implementation analysis have been proposed by Hambleton (1983) and O'Toole (1986). Applied to the major healthy public policy frameworks, they suggest a wide range of research topics, to be discussed in Chapter 6; but our review suggests that some priority be given to the question of centralization versus decentralization in relation to the degree of success of implementation.

Finally, our review has emphasized the need to examine, through research, the impact of the social and political macro-environments on all phases of the healthy public policy process. This recommendation parallels Milio's (1987b) call for increased research attention to the "social climate" of policy in general, and health promotion in particular.

REFERENCES

- Angus, Douglas E. and Manga, Pran. National health strategies: Time for a new 'New Perspective'. *Canadian Journal of Public Health*, 77, March/April 1986:81-84.
- Baggot, Rob. Alcohol, politics and social policy. *Journal of Social Policy*, 15(4), 1986:467-488.
- Barer, Morris L., Evans, Robert G., Stoddart, Greg L., Labelle, Roberta and Fulton, Jane. *Lifestyles, linkages and liabilities: Theory and evidence justifying economic incentives for healthier lifestyles*. Program for Quantitative Studies in Economics and Population, Faculty of Social Sciences, McMaster University, Hamilton, Ontario. QSEP Research Report No. 112, 1984.
- Barrett, Susan and Hill, Michael. Policy, bargaining and structure in implementation theory: Towards an integrated perspective. *Policy and Politics*, 12(3), 1984:219-240.
- Blum, Henrik L. *Planning for Health: Generics for the Eighties*. New York: Human Sciences Press, 1981.
- Bowen, Elinor R. The Pressman-Wildavsky paradox: Four addenda or why models based on probability theory can predict implementation success and suggest useful tactical advice for implementers. *Journal of Public Policy*, 2(1), 1982:1-22.
- Duhl, Leonard J. *Health Planning and Social Change*. New York: Human Sciences Press, 1986a.
- Epp, Jake. National strategies for health promotion. *Canadian Journal of Public Health*, 77, July/Aug 1986:243-247.
- Fox, Daniel M. The consequences of consensus: American health policy in the twentieth century. *The Milbank Quarterly*, 64(1), 1986:76-99.
- Gemmill, Gary and Smith, Charles. A dissipative structure model of organizational transformation. *Human Relations*, 38(8), 1985:751-766.
- Ham, Christopher and Hill, Michael. *The Policy Process in the Modern Capitalist State*. Sussex: Wheatsheaf Books, 1984.
- Hambleton, Robin. Planning systems and policy implementation. *Journal of Public Policy*, 3(4), 1983:397-418.
- Health for All Ontario. Report of the Panel on Health Goals for Ontario, August 1987.
- Health Promotion: Concept and Principles, In Action, A Policy Framework. Unpublished discussion document. Copenhagen: World Health Organization, Regional Office for Europe, 1986.
- Health Promotion Matters in Ontario. Report of the Minister's Advisory Group on Health Promotion, 1987.
- Jackson, Suzanne Fraser. Planning for health in a changing society. A study of the relationship between a changing social paradigm, turbulence, non-conventional health care practices and planning. Unpublished doctoral dissertation. University of Waterloo, 1981.
- Lalonde, Marc. *A New Perspective on the Health of Canadians*. Ottawa: Health and Welfare Canada, 1974.
- Lamb, Jr., Charles. Public sector marketing is different. *Business Horizons*, July/August 1987:56-60.
- Lane, Jan-Eril. Institutional innovation and implementation: The case of Sweden. *Policy Studies Journal*, 14(3), 1986:470-478.
- Lee, Kenneth and Mills, Anne. *Policy-making and Planning in the Health Sector*. London: Croom Helm, 1982.
- Lewin, K. *Field Theory in Social Science*. New York: Harper and Row, 1951.
- Linder, Stephen H. and Peters, B. Guy. From social theory to policy design. *Journal of Public Policy*, 4(3), 1984:237-259.
- Linder, Stephen H., and Peters, B. Guy. A design perspective on policy implementation: The fallacies of misplaced prescription. *Policy Studies Review*, 6(3), 1987:457-475.

- Mason, Richard O. A dialectical approach to strategic planning. *Management Science*, 15(3), 1968:403-414.
- Mayntz, Renate. Public bureaucracies and policy implementation. *International Social Science Journal*, 31(4), 1979:633-645.
- Mayntz, Renate. The conditions of effective public policy: A new challenge for policy analysis. *Policy and Politics*, 11(2), 1983:123-143.
- McKnight, John. Professionalized service and disabling help. In I. Illich et al. (eds.), *Disabling Professions*. Toronto: Burns and MacEachern, 1977:69-91.
- McKnight, John. Regenerating community. *Social Policy*, Winter 1987:54-58.
- Meijer, A.W.M. Some aspects of alternative approaches to planning. In Charles O. Panneborg, Albert van der Werff, Gary B. Hirsch, and Keith Barnard (eds.), *Reorienting Health Services: Application of a Systems Approach*. New York: Plenum Press, 1984:69-89.
- Milio, Nancy. Personal Interview, October 28, 1987b.
- Morgan, Gareth. Emerging managerial competencies. (Draft) In *Riding the Cutting Edge of Change: Emerging Managerial Competencies*. San Francisco: Jossey-Bass, In press.
- Morgan, Gareth, and Ramirez, Rafael. Action learning: Metaphor for guiding social change. *Human Relations*, 37(1), 1983:1-28.
- Nutt, Paul C. *Planning Methods for Health and Related Organizations*. New York: John Wiley & Sons, 1984.
- O'Toole, Laurence J. Policy recommendations for multi-actor implementation: An assessment of the field. *Journal of Public Policy*, 6(2), 1986:181-210.
- Porter, Michael. The case for rethinking strategic planning. *The Globe and Mail*, June 8, 1987:B1, B6.
- (A) *Proposal to Establish Health Objectives and Strategies for Canada*. Discussion paper submitted by the Canadian Public Health Association with support and assistance from the Ontario Public Health Association, September 1985.
- Reeves, Philip N., Bergwall, David F. and Woodside, Nina B. *Introduction to Health Planning*. Arlington, Virginia: Information Resource Press, 1984.
- Roberts, Jan and Colvin, Phyllis. Personal communication. October 28, 1987.
- Robertson, David Brian. Program implementation versus program design: Which accounts for policy failure? *Policy Studies Review*, 3(3-4), 1984:391-405.
- Sabatier, Paul A. Top-down and bottom-up approaches to implementation research: A critical analysis and suggested synthesis. *Journal of Public Policy*, 6(1), 1986:21-48.
- Sabatier, Paul A. and Mazmanian, Daniel. The conditions of effective implementation: A guide to accomplishing policy objectives. *Policy Analysis*, 5(4), 1979:481-504.
- Segall, Malcolm. On the concept of socialist health system: A question of Marxist epistemology. *International Journal of Health Services*, 13(2), 1983:221-225.
- Siler-Wells, Gail. An implementation model for health system reform. *Social Science and Medicine*, 24(10), 1987:821-832.
- Solesbury, William. Strategic planning: Metaphor or method? *Policy and Politics*, 9(4), 1981:419-437.
- Spitzer, Robert J. Promoting policy theory: Revisiting the arenas of power. *Policy Studies Journal*, 15(4), 1987:675-689.
- Thain, Colin. Implementing economic policy: An analytical framework. *Policy and Politics*, 15(2), 1987:67-75.
- Thompson, Frank J. Implementation of health policy: Politics and bureaucracy. In Theodor J. Litman and Leonard S. Robins (eds.), *Health Politics and Policy*. New York: John Wiley and Sons, 1984:145-168.
- Thrasher, Michael. Exchange networks and implementation. *Policy and Politics*, 11(4), 1983:375-391.
- Toward a Shared Direction for Health in Ontario. Report of the Ontario Health Review Panel, 1987.
- Waitzkin, Howard. Health policy and social change: A comparative history of Chile and Cuba. *Social Problems*, 31(2), 1983:235-248.
- Wallerstein, Immanuel. Economic cycles and social policies. *Futures*, 16(6), 1984:579-585.
- Wildavsky, Aaron. *Speaking Truth to Power: The Art and Craft of Policy Analysis*. Boston: Little, Brown, and Company, 1979.
- Wittrock, Bjorn and DeLeon, Peter. Policy as a moving target: A call for conceptual realism. *Policy Studies Review*, 6(1), 1986:44-60.
- Wolman, Harold. The determinants of program success and failure. *Journal of Public Policy*, 1(4), 1981:433-464.
- Woodside, Kenneth. Policy instruments and the study of public policy. *Canadian Journal of Political Science*, XIX(4), 1986:775-793.
- Ziglio, Erio. Uncertainties and dilemmas in future health policy scenarios: Some cautionary issues. *Futures Research Quarterly*, 2(4), 1986a:5-16.
- Ziglio, Erio. Policy-making and planning in conditions of uncertainty: Theoretical considerations for health promotion policy. Draft working paper No. 7, Research Unit in Health and Behavioural Change, Edinburgh, Scotland, 1987a.

Chapter Five

MECHANISMS FOR COORDINATING HEALTHY PUBLIC POLICY

The previous chapters introduced major elements in the development and implementation of healthy public policy. We have argued that the characteristics of healthy public policy, that is, that it is multisectoral, participative, multidisciplinary, and focuses on issues of equity in health, generate a need for new or revised processes of developing and implementing public policy. The focus of this chapter is on the processes and mechanisms of coordination. Healthy public policy appears to require new arrangements between and within organizations which facilitate communication and cooperation. While it is recognized that coordination in Canada is complicated by the existence of a constitutional separation of powers for the responsibility of delivering medical services between the federal and provincial governments, the emphasis in this chapter is on intersectoral rather than interjurisdictional coordination.

The discussion commences with a general sketch of topics important to coordinating healthy public policy such as defining the meaning and purpose of coordination and recognizing the tension between a call for greater coordination and for increased public participation simultaneously, both of which are features of healthy public policy. Some theoretical material on interorganizational conflict and collaboration is introduced. This theoretical area may prove to be a valuable resource for advocates of healthy public policy. Milio (1987a, 1987b), however, stresses the need to "learn by doing". The chapter therefore concludes with a discussion of experiences with healthy public policy in various jurisdictions, ranging from the national to the local level.

DILEMMAS IN COORDINATING HEALTHY PUBLIC POLICY

Coordination, Cooperation, or Collaboration?

The coordination of healthy public policy has been identified as an important aspect of health promotion in *Achieving Health for All* (1986). As has been a common concern throughout this review, those in-

terested in pursuing this recommendation to coordinate public policies for health face difficulties with terminology. The literature is filled with different uses of this term and a precise definition of what coordination means is not given in *Achieving Health for All*. Some of the variants in the use of the term "coordination" are outlined below.

Stahlberg (1983:451) does not distinguish variations in coordination with different terms, but recognizes that coordination can range from an intense partnership through to minimal coordination in which "two plans are published within the same covers". Booth (1981:25), however, distinguishes between coordination and collaboration: "Coordination means working independently but in harmony; collaboration means working together." Gray (1985:912) defines collaboration even more precisely as "(1) the pooling of appreciations and/or tangible resources, e.g. information, money, labor, etc., (2) by two or more stakeholders, (3) to solve a set of problems which neither can solve individually". The pattern which emerges from these three examples is that a continuum of intensity of interaction between individuals or organizations can be drawn which places independent action at one end, collaboration at the other, and coordination somewhere in between. Such distinctions may be important in the context of healthy public policy as it may be easier to gain support for coordination than collaboration. Coordination, as it is defined here, however, may prove inadequate in dealing with the complex problems outlined by the many task forces and individuals examining the health field (e.g. *Toward a Shared Direction for Health in Ontario*, 1987; Milio, 1986c). Moreover, the notion of collaboration provided by Gray (1985) seems consistent with the intention of *Achieving Health for All*, which does not, as previously noted, make its definition explicit. This suggests, however, that it is collaboration with which we must be concerned.

The World Health Organization (*Intersectoral Action for Health*, 1986) does not use the term coordination with reference to healthy public policy but rather the term cooperation. The use of the term 'cooperation', however, cannot circumvent the issues noted

above, though it may suggest a looser form of interaction than is implied by collaboration.

Weiss (1981) and Booth (1981) both urge that the meaning and purpose of coordination be clear to the various actors in any particular instance of developing or implementing policy. Without a common understanding of the nature and intent of coordination in a particular instance, the various actors may end up working at cross purposes. A common understanding may be especially important in the field of healthy public policy given the large number of interests involved and if the inherent appeal of calls for coordination is as seductive as Weiss (1981) suggests.

Symbolic Appeal of Calls for Coordination

Weiss (1981: 21) warns administrators of human service organizations against the seductive "symbolic and expressive content of the coordination message"; she worries that the powerful emotional appeal of coordination programs and policies can mask the poor performance of such programs. The symbolic power of coordination may lie in the way it evokes "widely shared values of rationality, comprehensiveness, and efficiency, thus reinforcing public confidence in the role of reason in policy making" (Weiss, 1981: 37). However, as the previous chapter has indicated, policy making is not always a highly rational enterprise, but often a combination of planning, opportunism, personality and politics. The point to be made here is not that the call for coordination inherent in the conceptualization of healthy public policy is misplaced, but that its powerful emotional appeal may be both a strength and a weakness. In addition, the goal of introducing this issue is to draw attention to the confusion over the purposes and intent of coordination that may exist, both because of the large number of actors which must become involved in the domain of healthy public policy and because of the symbolic power of the word itself.

The Need for Participation

The dilemma between a call for coordination and a call for increased public participation was alluded to in the previous chapter. While this issue falls more properly within the domain of a review on fostering public participation, it is important to acknowledge it in this review as well. Essentially, the dilemma is how to enhance coordination and participation simultaneously. At first glance, coordination appears to imply greater centralization, whereas enhanced public participation appears to imply greater decentralization. Certainly, decentralization is advocated for strategies of intersectoral action and regional and local levels (see "The role of intersectoral cooperation in national strategies for Health for All", 1986). Trying to achieve both of these objectives at the same time may be utopian; however, achieving some balance between them seems essential. Perhaps one way through this dilemma is

through articulating a clear conceptualization of the goals of coordination and participation, ensuring that these views are widely communicated to interested and affected parties (Weiss, 1981; Booth, 1981). Such an articulation may facilitate the achievement of both aims.

In addition, the goals of decentralization and participation have been inadequately articulated in the literature on healthy public policy. For example, decentralization can easily turn into rhetoric-supported "passing the buck" if it is used as a cost-saving gesture by central governments who simply pass on the responsibility for social programs to lower levels of government. Additionally, just how decentralization will benefit public participation in health planning and healthy public policy has yet to be realized. Finally, Pannenberg (1985) reminds us that decentralization introduces the risk that services will not be equitably distributed with the result that social inequities will develop or may be exacerbated.

Interorganizational Conflict and Collaboration

Efforts to place health explicitly on the agenda of policy makers in traditionally non-health areas demands collaboration and will almost certainly generate intra- and interorganizational conflict. The relatively new field of interorganizational relations (DiStefano, 1984) appears to be a good source of material on both conflict and collaboration, though there are theorists who discourage the separation of the literature into intra- and interorganizational domains (see Fombrun, 1986). Facets of conflict and collaboration will each be dealt with briefly here.

While conflict may be problematic, creative innovations in conflict management are being studied and applied (e.g. Gray and Hay, 1986; Mueller, 1984) and there is evidence to suggest that conflict is valuable in overcoming inertia and complacency (Rahim, 1985). Rahim (1985:81) contends that conflict, which he defines as "an 'interactive state' manifested in disagreement, differences, or incompatibility, within or between individuals or groups", can be functional to organizations, particularly if it is looked upon as something to be managed rather than resolved. Whether or not this suggestion can be extended to the complex interorganizational sphere of healthy public policy is uncertain however, his proposal that conflict can be managed through diagnosis and intervention at appropriate levels (individual, interpersonal, group and intergroup) and with appropriate strategies suggests that greater research in this area may be fruitful.

Gray (1985), extending the work of Trist (1977, 1983), speaks clearly to why healthy public policy is the kind of problem area in which collaboration is appropriate. Gray (1985) suggests collaboration is warranted in situations in which a problem is "indivisible" (Aldrich, 1976), that is, too complex for a single organization acting alone to solve. Collabora-

tion is also encouraged when traditional adversarial methods of problem solving such as litigation are too limited to resolve a problem in ways that are acceptable to the various parties, and under conditions of environmental turbulence. "Turbulence occurs when large, competing organizations, acting independently in diverse directions, create unanticipated and dissonant consequences for themselves and others" (Gray, 1985:912). The need for collaboration also arises when organizations are interdependent, that is, when the strategies of one organization are dependent upon the actions of another (see also Tjosvold, 1986). Finally, Gray suggests that if organizations can work together to conceptualize problems and organize solutions at the "domain" level, there is greater likelihood of solving the problem. Gray uses the term domain as it was defined by Trist (1983) to mean the set of actors that become joined by a common problem or interest. Thus, public policies for health can be conceptualized as belonging to a domain which links the various sectors of housing, education, agriculture, transportation, and so on. Building on this theoretical foundation, Gray suggests conditions which may facilitate interorganizational collaboration.

Gray conceptualizes collaboration as a process which proceeds through three phases: problem-setting, direction-setting and structuring. "Successful collaboration ... depends upon the simultaneous interaction of several conditions at appropriate phases in the process" (Gray, 1985:932).

Problem-setting involves identifying the stakeholders within a domain and their mutual acknowledgment of the issue which joins them. (Gray does not explicitly define the term "stakeholder", though she does suggest that a stakeholder is anyone with a legitimate "stake" in an issue. This definition introduces the question of who defines what a legitimate interest or stake is, which is an issue that Gray addresses more directly.) Problem-setting is facilitated by identifying the stakeholders within a domain, bearing in mind that the set of stakeholders needs to reflect the complexity of the problem under consideration (i.e. include enough people to ensure that the entire range of views on the subject are represented). Problem-setting is further enhanced when stakeholders expect the benefits of collaboration to outweigh the costs, when they recognize their interdependence, perceive one another as having a legitimate interest in the problem at hand, and when the initiator of the collaborative effort possesses legitimate authority to convene discussion among the other stakeholders.

After problem-setting, the stakeholders proceed into a phase of direction-setting which involves the stakeholders acknowledging the values which guide their actions and decisions. This phase is facilitated by a coincidence of values among the stakeholders and a dispersion of power among the stakeholders.

The third phase of collaboration is structuring, in which a mechanism to regulate collaborative activities is established. This final phase, which Gray stresses is dynamic rather than static, is facilitated when stakeholders perceive that their continued dependence upon one another is necessary to implement their plans. Structuring is also enhanced when collaboration is voluntary rather than mandated; power has been allocated throughout the stakeholders in a mutually acceptable manner; stakeholders are in close physical proximity; and when factors in the environment external to the domain require ongoing management and action if the stakeholders within the domain are to achieve their desired ends. This last condition might include instances, for example, in which efforts such as lobbying or coalition building are needed to influence activities in a desired direction. These conditions can be incorporated into a strategy for intersectoral coordination for healthy public policy. Understanding the conditions which facilitate collaboration may be particularly relevant when the discussion of stakeholders moves beyond the government to include private industry, citizens, health care providers and even other nations.

Feasibility of Healthy Public Policy

The preceding issues in healthy public policy may all be subsumed under the rubric of feasibility; however, Milio (1987a) suggests additional issues which are inherent in the question of feasibility.

'Feasibility,' of course, has several facets: economic is it affordable? political is it supportable by key constituencies? administrative can it be effectively organized? Each facet is related to the others: what is politically feasible is often found to somehow be affordable and workable, although a policy thought to be costly or complex does not easily gain political support.

Feasibility is not a given. It is a matter of perception, timing, and timeliness with respect to other problems, priorities and changes in the social "climate." This means that the feasibility of healthy public policy can be enhanced within each country. In turn, that requires strategic planning based on astute views of national realities (Milio, 1987a:3).

In sum, Milio (1987a, 1987b) suggests that the central issue facing healthy public policy at this time is how to enhance the feasibility of placing health criteria on the agendas of policy makers who have previously not considered health part of their domain. This may imply new roles for many stakeholders including the recognition that individuals not previously considered as stakeholders in the health domain ought to be considered as such.

ROLES OF STAKEHOLDERS IN HEALTHY PUBLIC POLICY

This section outlines some of the possible roles for various stakeholders in the domain of healthy public policy. Key stakeholders include government, the private sector, health care providers, voluntary associations, academia, the media and individual citizens.

Government

As stated at the outset, Milio (1986a) argues the case for public policies which foster health on the basis that public policy shapes the environments in which organizations operate and individuals live their lives. As public policy is therefore an important variable in the determinants of health, Milio contends that the health impacts of public policy ought to be given explicit consideration. The role of government is thus "to assure that individuals and organizations have usable opportunities for making choices between health-promoting and health-damaging alternatives" (Milio, 1986a:6). These sentiments are repeated by Hancock (1987), Macpherson (1987), and the World Health Organization (*Targets for Health for All*, 1985), among others.

Given this general role for government, the WHO (1985) claims there is need for demonstrations of political will to raise the profile of health issues and to improve the environment. It is suggested that government needs to provide visible leadership in the shifting of priorities toward healthy public policy (*Targets for Health for All*, 1985).

Within the overall role of government to assure that health promoting options exist, the role of the Ministry of Health has been widely discussed (see Milio, 1986c). Many of the major documents mentioned in Chapter 2 discuss the role of the Ministry of Health in the initiation of healthy public policy (e.g. *Toward a Shared Direction for Health in Ontario*, 1987). In general, the documents advocate that the Ministry of Health act as the lead ministry in initiating a dialogue on public policies for health (see e.g. *Targets for Health for All*, 1985). It is also suggested that the Ministry of Health play an advocacy role on behalf of health within the government bureaucracy and the political arena. The Ministry of Health can also foster community dialogue on health issues, encourage research in areas which support the establishment of healthy public policies, and advocate the establishment of intersectoral advisory committees within the bureaucratic and political arms of government (Milio, 1986c).

Milio (1987a:15) summarizes the current priority for government with respect to implementing healthy public policy as "capacity building". Capacity building refers to the conscious development of new skills in analysis, education and collaboration as well as the building of infrastructures for collaboration.

Healthy public policy requires a gradual transition away from a consideration of narrow sectoral interests to a broader view of the determinants of health among both politicians and bureaucrats. Ultimately, Milio (1987a) argues, there must be a reallocation of strategic resources (money, personnel) to pursue healthy public policies.

Federal-Provincial Relations

Within Canada, the role of government is circumscribed by a constitutional separation of responsibilities in the health care sector between the federal and provincial governments. *A New Perspective on the Health of Canadians* (Lalonde, 1974) directly addresses this issue. The report argues that in spite of the fact that the provinces are directly responsible for the provision of health services, a wider conception of health, as provided by the Health Field Concept, justifies a larger role for the federal government than has been exercised to date. An enlarged role for the federal government is justified on the grounds that health problems know no provincial boundaries and that matters of national importance ought to be dealt with by the federal government with the support and input of the provinces:

The Health Field Concept disregards questions of jurisdiction which may be important to governments but are not of primary concern to the people of Canada when their health is at stake. It identifies requirements for health without regard to the niceties of professional or sectoral boundaries, and it focuses attention on the broad and important factors underlying the health of the population (Lalonde, 1974:63).

Biology, the environment and lifestyles, it is further argued, are national in character even if the organization of the medical care system falls under the domain of the provinces. Essentially, the federal role identified by *A New Perspective* is to be one of leadership.

The enlarged federal role in health conceptualized in the Lalonde report has not materialized, though there have been significant changes in the funding arrangements between the federal government and the provinces, first through alterations in the block grants between the federal and provincial governments in 1977 and more recently under the Canada Health Act of 1984. Federal leadership and participation in health certainly exists, however, as is attested to by the development of *Achieving Health for All* (1986). The problems which plagued the implementation of *A New Perspective* may arise in the implementation of *Achieving Health for All* also.

Evans (1982) argues that *A New Perspective* failed to generate significant changes in health care in Canada because the report permitted many variations in interpretation to be made by the various in-

terest groups: government, providers, private sector. These different interpretations, Evans contends, generated conflict which was not easily reconciled politically. Hancock (1986a) suggests that the federal-provincial jurisdictional issue was a significant barrier to implementing *A New Perspective*. Though the jurisdictional issue was addressed in the document, mechanisms for dealing with this conflict were neither proposed nor subsequently developed.

Private Sector

The role of the private sector in establishing healthy public policy has not been well developed in the literature, possibly because it is perceived that the initial, significant thrust in this development must come from government. Nevertheless, the private sector, through policies of individual organizations and through the products and services it produces (or does not produce), influences the choices of consumers with respect to food, housing, transportation, etc. In some instances, such as in the tobacco industry, products are produced which have been identified as harmful to health. Experiences throughout the world have indicated the resistance of the tobacco industry to efforts to control consumption (see, for example, Leppo and Vertio, 1986; Calnan, 1984; Popham, 1981; Harrison and Tether, 1987).

The private sector is also the major employer in most Western nations, and as such it is implicated in quality of work life and occupational health and safety discussions. Finally, the private sector is in some instances the source of serious environmental health threats, implying that it has a responsibility with respect to the health implications of its activities. Given these factors, the private sector is an essential constituency for participation in the development of healthy public policies.

Health Care Providers

There is considerable interest in the literature in the role of various health professionals in health promotion (e.g. Wilkins and Hoey, 1985; Jaffe, 1986; Squires, 1987; Terris, 1987; Roemer, 1984; Fowler, 1985). Most of these articles encourage the adoption of a more preventive stance in the practice of the particular profession with which the author is familiar or argue that the unique skills and/or training of the members of that professional group means that they have important contributions to make to the practice of health promotion. Concern has been expressed, however, that the medicalization and/or professionalization of health promotion is antithetical to the conceptualization of health promotion as "the process of enabling people to increase control over, and to improve, their health" (*Health Promotion: Concept and Principles*, 1986:4; *Vienna Dialogue*, 1987). That concern notwithstanding, clearly health professionals are a major stakeholder in healthy pub-

lic policy, though there is as yet little material on the role of health care providers in healthy public policy per se.

Hancock (1985a:13), however, has speculated that healthy public policy implies a reduced role for health professionals in the future:

If the health care system is not a prime determinant of health, if our high-tech medicine is causing problems and is more expensive than we can afford, and if personal and community responsibility is to be encouraged, then we clearly need fewer health professionals in general, and in particular fewer highly trained professionals.

Other facets of the health professional's role are likely to be a focus on prevention rather than cure and teaching self-care skills (Hancock, 1982). Finally, Hancock (1982) proposes that the settings for health care delivery will include more community health centres, out-patient departments, and home care; this implies significant changes in the work settings for many health care providers.

Milio (1986c:129) emphasizes that the health services alone "cannot equalize opportunities for health" and hence will need to work collaboratively with other sectors of society to improve health. Milio's suggestion implies an emphasis in the training of health professionals on collaborative working arrangements and collective problem-solving.

Whatever model of health service delivery develops, health care providers have a major role to play in determining its form and in the formulation of public policies for health as advisors, consultants, and caregivers. This role has been recognized in virtually all recommendations for intersectoral advisory committees and task forces to date (e.g. *Toward a Shared Direction for Health in Ontario*, 1987).

Voluntary Associations

Some voluntary associations, such as the Canadian Public Health Association (CPHA) and its provincial affiliates, have already indicated their interest in participating in the development of public policies for health in Canada. For example, CPHA worked collaboratively with the World Health Organization and Health and Welfare Canada, to sponsor the 1986 international conference on Health Promotion in Industrialized Countries; Milio's (1986a) seminal work on healthy public policy was published in Canada under the auspices of CPHA; and CPHA prepared a discussion document in 1985 to establish national health objectives and strategies for Canada. That the public health constituency should be supportive and interested in participating in the development of healthy public policy is perhaps not surprising, given the historic tradition of public health in non-health sectors. The WHO has also articulated a role for pub-

lic health associations and professionals as advocates on behalf of health promotion and healthy public policy (Tejada-de-Rivero, 1984; Vuori, 1985).

Other nongovernmental organizations besides the public health associations have a role to play in healthy public policy as representatives of communities and interest groups (White, 1986). Some groups, like Paradigm Health in Ontario, have attempted to influence public policy in a health promotion direction already (*A Vision for A Healthy Ontario*, 1986). A Canadian Medical Association task force has sought information from the health system user's perspective on needed reforms which it has recently released as a report (*Health: A Need for Redirection*, 1984). Such initiatives indicate the interest of professional associations and voluntary groups in the future of health in Canada.

Academia

The role of academia in healthy public policy is to provide research-based support and training in the thinking and skills necessary to implement multisectoral policies. The health promotion activities in the Mersey Region of England are actively linked to the Liverpool University Department of Community Medicine (Ashton, Seymour, Ingledew, Ireland, Hopley, Parry, Ryan and Holbourn, 1986). In particular, the university is assisting with the coordination of the WHO Healthy Cities project by acting as a resource centre which generates and disseminates information. As noted earlier, universities and colleges also play an important educational and training role for health professionals. Finally, universities are a primary site of research activity and hence an important entity in supporting strategies of healthy public policy.

Media

Media is not only a means of conveying the opinions of interest groups, but an interest in and of itself. Milio (1981:733) stresses that mass media tend to "oversimplify and sensationalize issues" with the result that complex issues are misrepresented to audiences. Tele-matics, which is the term for the new information technologies, also will play a role in health in terms of the health impacts of using them and of their capacity to convey health information (Milio, 1985b).

Individual Citizens

Hancock (1987a) suggests that direct involvement of the citizen in healthy public policy is most likely at the local level, for example in a neighborhood association or community group. Hancock (1987a) proposes that participation becomes more limited and citizens depend on various forms of representation to express their views to policy makers once the forum moves beyond the local level. For example, people may express their views through financial contributions or voluntary labour to associations and organizations whose

policies and goals they endorse, and by electing official representatives to all levels of government.

Milio (1986c:130) suggests that in the context of healthy public policy, "the responsibilities of individuals are to engage in informed participation and to adopt, when appropriate, new ways of doing which collective action can encourage". Hence, Milio (1987a, 1987b) advocates "capacity building" for groups; this might include developing the skills and resources to facilitate participation in the policy-making process.

EXPERIENCES IN HEALTHY PUBLIC POLICY COORDINATION

There is a growing body of literature which describes, and to some extent analyzes, examples of healthy public policy in various jurisdictions (e.g. Ziglio, 1986b; Moran, 1986; Seymour, Ashton, and Edwards, 1986). Still, Milio (1987a:4) characterizes these attempts at intersectoral action for health as "tenuous beginnings". It is hoped that an examination of experiences in other jurisdictions may facilitate the implementation of healthy public policy in Canada, though Ashford (1984) reminds us of the limited generalizability of the experience of one country to another from "snapshot" policy analyses.

To date, the most thorough documentation is available for initiatives in the Scandinavian countries, particularly Norway (see Ziglio, 1986b; Milio, 1981, 1987a; Klepp and Forster, 1985). Material is available on initiatives at all levels from national to local. Truly international efforts, i.e. those which involve more than one nation, do not yet appear to be under way, though this level of initiative is advocated in *Targets for Health for All* (1985). The mechanisms for most of the initiatives include the establishing of intersectoral committees at the political and bureaucratic levels to facilitate intersectoral communication and policy development.

Milio (1987a), following an extensive international survey of public policies for health, suggests a useful typology for characterizing variants in the development and implementation of healthy public policy. She suggests that three approaches have been undertaken to introduce public policies for health: a targeted approach, a policy-planning structures approach, and a participatory planning process. Targeted approaches focus on a specific area of public policy or on a particular disease or problem area amenable to influence by public policy; examples include smoking control (e.g. Leppo and Vertio, 1986) and Norway's farm-food-nutrition policy (Milio, 1981).

Policy-planning structures approaches entail the development of new policy-making machinery to facilitate the development of intersectoral policies. Typically, such mechanisms consist of intersectoral advisory or decision-making committees which can facilitate the collaboration of stakeholders in the

policy development process. The policy-planning structures approach is commonly advocated in the literature (see *Targets for Health for All*, 1985).

The third approach involves establishing mechanisms for public participation in policy development. Milio (1987a) suggests that this approach has been successfully used in Australia in reviewing and enhancing intersectoral policies aimed at women.

The three approaches in this topology are not mutually exclusive; many of the case studies in the literature incorporate elements of each strategy. The purpose of the topology, however, is to identify different emphases adopted in different locations and different policy environments. Such an identification process may be of use in understanding the conditions which facilitate the development of healthy public policies.

National Initiatives

Norway's farm-food-nutrition policy may well be the most studied instance of intersectoral policy for health in the world (see, for example, Milio, 1981, 1987a; Hancock, 1987c; Klepp and Forster, 1985; Ziglio, 1986b). Initiated in 1975, implementation of this policy involved the establishment of new intersectoral machinery in both the bureaucracy and among elected officials. A nine-member Interministerial Coordinating Council (ICC), chaired and staffed by the Health Directorate has been established at the political level. It is supported by a reorganized expert National Nutrition Council (NCC) which provides advice and education (Ziglio, 1986b). Additional support and participation in the ongoing implementation of the policy is provided by national research institutes and formal ties through various ministries to a variety of consumer, community and agricultural organizations. The goals of the Food and Nutrition Policy are to improve Norwegian dietary habits, to increase the production and consumption of food produced domestically, to promote greater self-sufficiency in food production, to enhance rural economic development, and to formulate a nutrition and food policy in accordance with recommendations from the 1974 World Food Conference (Ziglio, 1986b). Alterations in dietary habits have been supported through changes in the subsidies on various food products for both consumers and producers (Ziglio, 1986b). Greater self-sufficiency and regional development have been encouraged through quotas, production remuneration and investment subsidies (Ziglio, 1986b). While it is not certain that Norway will attain its goals in this area by its 1990 target date (Milio, 1987a), it is clear that some of the patterns in consumption (for example of saturated fats) have altered in the desired direction and that progress on the various goals is being made (Ziglio, 1986b).

Sweden adopted a targeted approach in its Work Environment Act which provides a comprehensive view of occupational health and safety that extends beyond clinical and educational services to encompass issues

such as working hours, work organization and the effects of piecework on health and safety (Milio, 1987a). The implementation of this legislation involves joint management-labour committees, elected safety representatives, and funding for training, research and evaluation of decision-making and workplace issues. These activities are funded through a payroll tax scheme and administered through a national Work Environment Fund (Milio, 1987a).

Finland has used a targeted approach in tackling the issue of unemployment. Malkas (1985) reports that health criteria were taken into account by the Ministry of Labour in its planning for programs to deal with youth unemployment in the 1970s, although this health emphasis has apparently lessened in the leaner economic times of the 1980s.

Milio (1987) reports that the policy-planning structures approach has been adopted in Sweden, Canada and Ireland. Sweden, in addition to its targeted programs for occupational health and safety, has initiated a comprehensive new health policy (*Health in Sweden*, 1982). This new policy calls for an Intersectoral Health Council which will be composed of ministers from housing, physical planning, labour, public administration, finance, agriculture, transport and communications; it is supported by expert staffs (Milio, 1987a). As with Norway's nutrition policy, a complementary intersectoral group exists within the bureaucracy, the Health Education Division of the National Board of Health and Welfare, to initiate intersectoral activity with other national boards, and elected officials at the county and municipal levels. As well, the Health Education Division supports non-governmental organizations and is responsible for planning, research and evaluation of health promotion. Ultimately, intersectoral health action will occur at the local level through the local health authorities which are under the elected local Council Government.

In Canada, recent initiatives which are national in scope provide useful examples of targeted healthy public policies, in Milio's sense. In 1987, the Ministers of Health, Justice, Labour and the Secretary of the Treasury Board announced a tobacco policy which would strengthen the existing prevention program by adding efforts to achieve cessation and by adding a regulatory strategy, the Tobacco Control Act (*Directional paper of the national program to reduce tobacco use in Canada*, 1987). In the same year, the Ministers of Health, Justice and Transport announced the National Program Against Driving While Impaired. This initiative was preceded by extensive community consultations (Rootman, 1987). Also in 1987, in a federal-provincial initiative involving eleven ministries of the federal government, a National Drug Strategy, *Action Against Drug Abuse*, was announced. This program was developed after cross-country consultation at the community level. A comprehensive program addressing alcohol and prescription drugs, in addition to illicit drugs,

aims at prevention, treatment, control and enforcement (Rootman, 1987). These initiatives, while clearly multisectoral, address fairly traditional health-related problems. They are considered healthy public policy initiatives because innovative approaches, involving multisectoral and community-based consultation, were taken to address these problems. Canada has also had considerable experience in interjurisdictional, i.e. federal-provincial, coordination and consultation (Rootman, 1987); such experience should be of value to other nations with federal systems of government.

A multidisciplinary group in Ireland was charged by the Minister of Health to advise him on the creation of a health promotion strategy (Milio, 1987a). This group included senior individuals from the Health Department and the Health Education Bureau who drew upon additional outside resource people in health, academia and WHO for support and advice.

The final report recommends not a policy, but 'prior initiatives,' institutional changes to be taken in preparation for policy development. These call for widening the role of the Minister and of regional health authorities to include health promotion; broadening the mandate of the independent Health Education Bureau to address issues beyond the personal factors in health development; establishing an intersectoral Health Promotion Council, composed of public and private interests whose activities affect health, and staffed by the Ministry. It would identify health issues and be the main advocate for seeking action. A final proposal is to expand membership on the national Health Research Board to include economic, industrial, agricultural and other research organizations. Financing these organizational changes is to come from the redirection of current funds rather than new monies (Health Promotion Group, 1977 in Milio, 1987a).

The emphasis in these initiatives to develop policy planning for healthy public policy is on the formation of intersectoral and multidisciplinary committees with broad mandates. Both business and academia were commonly included in these policy planning structures endeavors. The importance of the research community in these new activities has also been articulated in some of the examples Milio (1987a) provides.

As noted earlier, experience in Australia in developing a National Agenda for Women exemplifies the participatory structures approach to healthy public policy development (Milio, 1987a). The National Agenda for Women involved the establishment of a new intersectoral budget arrangement, the Women's Budget, which requires an annual assessment of how the various Commonwealth Ministries relate to women. As well, the Agenda was originally outlined through an enormous consultative

process involving publicity, surveys and support for local and regional meetings. This process culminated in the Minister's announcement of a new health agenda for women which incorporates the WHO vision of health and establishes a women's health resource person to coordinate the development of the new policy. This participatory process was also used in the work of the Better Health Commission. Milio (1987a:12-13) comments that the "resources committed to these processes should contribute to the soundness and effectiveness of the policies that emerge, and eventually yield an acceptable pace of change".

Participatory processes were also used in New Zealand for dealing with intersectoral issues involving women (Milio, 1987a). After wide consultation, a Ministry of Women's Affairs has been established. As in health, virtually every Ministry has policies which have an impact upon women, making these models of intersectoral action and participation useful in considering how to go about developing mechanisms for healthy public policy.

Regional Initiatives

A number of Canadian provinces have demonstrated interest in intersectoral activities in the health area. Ontario, for example, has recently witnessed the release of the reports of two major task forces in the health field (*Toward a Shared Direction for Health in Ontario*, 1987; *Health for All Ontario*, 1987), both of which encourage the establishment of intersectoral strategies for establishing priorities for the future development of health in the province. The recommendation of the Ontario Health Review Panel that a Premier's Council on Health Strategy be established to "act as the driving force in developing a clear strategy for health..." (*Toward a Shared Direction for Health in Ontario*, 1987:62) has been adopted and a council has been established. This council includes representation from government, health care providers and the public, and will aim to identify a coherent strategy for health in the province. One step in the development of such a strategy might be adopting the health goals recommended by the Panel on Health Goals for Ontario and proceeding with the plan for developing objective and target statements outlined in that report.

A third report released in the fall of 1987, *Health Promotion Matters in Ontario*, reports on the results of a community dialogue project undertaken by the Minister of Health's Advisory Committee on Health Promotion. The report indicates that people conceive of health promotion as a broad concept incorporating a range of initiatives which promote health, from reducing pollution to greater access to recreational facilities to mandatory health education classes from kindergarten through high school. The report addresses the need for intersectoral cooperation to improve health and devotes several pages in

the appendix to outlining an example of intersectoral strategies for promoting physical activity and health knowledge. This outline includes suggested actions for the Ministry of Health, Ministry of Education, Ministry of Tourism and Recreation, Ministry of Attorney General, Ministry of Colleges and Universities, municipal governments, the Ontario Physical and Health Education Association (a professional organization of physical and health educators), and industry. The report suggests that, collectively, the actions of these various groups could provide significantly greater opportunities for physical education, recreation and health education in Ontario.

Regions in the United Kingdom do not correspond to the political and geographic regions of Canada's provinces. In the British context, regional initiatives are those which occur at some level higher than the local government level, for example, at the level of the Regional Health Authority, as opposed to the District or Local Health Authority. Numerous health promotion initiatives are under way in the Mersey Region of England, consisting of the city of Liverpool and environs (Ashton et al., 1986). Many of these initiatives incorporate some of the principles of healthy public policy. For example, on an organizational level, a multidisciplinary Regional Health Promotion Team (now known as the Health Promotion Management Steering Group) has been established within the Regional Health Authority. To date, "(t)he most important function of this team was to obtain access to the range of resources which exist within health authorities, and to open up channels of communication for influencing policy-making" (Ashton et al., 1986:175). A staff position of Regional Health Promotion Officer has also been developed, the first of its kind in the U.K. This position is jointly funded by the Health Education Council (a national body) and the Mersey Regional Health Authority. These organizational initiatives permit the Regional Health Authority to function in both a "top-down" and a "bottom-up" approach.

In terms of top-down activities, the Mersey Regional Health Authority has been heavily involved in political agenda-setting through such events as a Health Promotion Conference and the publication of a review of health status in the region. Bottom-up initiatives have been aimed at increasing awareness among the public as to the importance of health promotion.

The underlying expectation is that by mobilizing the public through increased knowledge and changes in attitude and understanding, leading to a greater confidence in public participation in health, individuals can become in a sense their own health experts. The collective effect of such a phenomenon should be a major improvement in the public health as a result of individual healthy choices, supported by increasingly responsive and healthy public

policies at a local and national level (Ashton et al., 1986: 176).

Two mechanisms used for community level awareness raising were health fairs and the transformation of a pub in Liverpool into a public health theme pub.

As a final note, the authors also acknowledge that for all they have been able to accomplish, there are limitations to working from a health authority base, primarily because of its long-standing role in hospital management as opposed to local health-related actions in cooperation with government. This comment suggests the value of the Canadian system of public health departments being situated in close proximity to local governments (Ashton et al., 1986).

State-level initiatives in health promotion are increasingly common in the United States. Most of the initiatives fall into Milio's (1987a) category of the targeted approach. Most commonly, activities are aimed at reducing the risks of developing cardiovascular diseases or cancer. Minnesota (Schultz, Moen, Pechacek, Harty, Skubic, Gust, and Dean, 1986) and Vermont (Thompson, Hamrell, and Coffin, 1987) are but two states with comprehensive cardiovascular disease reduction strategies involving multisectoral cooperation.

Local Initiatives

Some of the most visible and innovative examples of healthy public policy may be occurring at the local level. Gray's (1985) propositions for conditions which facilitate collaboration would suggest that the local level has several advantages when it comes to trying to initiate intersectoral activity. The recognition of interdependence among stakeholders may be more readily identifiable when the physical area of interest circumscribed as geographic proximity makes consultation and collaboration easier. As well, competition for the same scarce resources may facilitate the desire among various groups to come to workable decisions. Mueller (1984), on the other hand, suggests that the local level may resist innovations imposed from higher levels of government, especially if such innovations demand changes in established patterns of work. Thus, local implementation of national policies may be facilitated when the practices and behaviour of local officials is examined prior to the allocation of local responsibility for national policies.

Seymour, Ashton and Edwards (1986) outline a novel intersectoral project being developed for Liverpool a Body, Mind, City Museum. The museum is the newest version of a tradition of health education museums that has existed for some 75 years. The proposed museum would be a combination of Walt Disney style theme park and hands-on exhibitions about the body, mind and city. It is hoped that such a project would stimulate interest and enthusiasm about the human body and mind. Included in the development of the project proposal are the health, tourism, cultural and entertainment sectors. It is

hoped that ultimately the project will contribute to urban renewal and be self-sustaining.

Moran (1986) writes about healthy public policy at the level of the local authority in Britain. Public health used to be the responsibility of the local government, but in 1974 was absorbed into the National Health Service. The traditional emphases of public health on interventions in the physical environment have been supplanted under the medical focus of the NHS. Nevertheless, Moran (1986:199) contends that given "their statutory powers and the services they provide, all local authorities have policies on health promotion, whether by design or by default". Some local authorities, including the London Borough of Greenwich, have attempted to revitalize their public health initiatives and expand their deliberate health promotion activities, though often with a minimal staff (in the Greenwich instance, one person). Moran offers advice on the structures that must be in place if this revitalization is to be effective, particularly under the retrenchment climate in contemporary Britain.

Firstly, the scale of the task is far too great to be undertaken by a single individual, however talented and energetic. Rather than look for some reincarnation of the MOH [Medical officer of Health], therefore, authorities should be seeking more collaborative mechanisms which bring together disciplines from the whole range of activities. A Health Strategy Steering Group, on which all departments were represented at a senior level, would help establish these connections. In each case, the departmental representatives should be specifically responsible for the department's health policy for example, by initiating and updating the department's own reviews of the health impacts of its activities. The inter-departmental Steering Group could also include external representation from areas such as the NHS, community medicine, and local voluntary bodies (Moran, 1986:198-199).

At least two other London boroughs have demonstrated interest in incorporating a health promotion strategy into their activities, Bloomsbury and Paddington/North Kensington (Farrant, 1986; *Health for All 2000 and Health Promotion*, 1986). In each of these boroughs, the initial effort to gain intersectoral support for health promotion has come from the District Health Authority. It will be interesting to see whether this model of trying to influence the local government and bureaucracy from the health authority is successful, or whether greater leadership is needed from the local government itself. The use of an intersectoral committee to oversee policy and to guide the activities of the borough with respect to health promotion is similar to initiatives in Toronto with respect to the city's involvement in the WHO Healthy Cities project. Cer-

tainly, the Paddington and North Kensington experience of trying to introduce WHO-style health promotion planning has been difficult due to "the endemic problem of lack of effective mechanisms for ensuring meaningful public participation in NHS decision-making; and the complexity of assessing community-defined need" (Farrant, 1986:7). Non-coterminous boundaries between the health authorities and local authorities exacerbates the problems of coordinating planning and action.

The Healthy Cities (Duhl, 1986b; Hancock and Duhl, 1986) project grew within the WHO from, among other things, initiatives in Toronto during its sesquicentennial year. As part of the celebrations, the City of Toronto Department of Public Health held a conference on healthy public policy the Beyond Health Care conference. That conference has stimulated much of the international activity associated with healthy public policy and the creation of healthy cities (Ashton, Grey and Barnard, 1986). At present, a subcommittee of the Board of Health in Toronto has prepared and released a document entitled *Healthy Toronto 2000* (1987) which is intended to stimulate interest and action toward Toronto becoming a healthy city. Recently, the intersectoral "Committee of Heads" of the city has endorsed the project. Another local level initiative with intersectoral implications from Toronto is its recently established Environmental Protection Office (Macpherson, 1987; City of Toronto Department of Public Health Memorandum, 1987). An interdepartmental task force was integrally involved in the development of the proposal to establish this office, which is situated within the Department of Public Health. The principal function of this office is "to provide environmental research and investigation services to the Board of Health, City Council, its Standing Committees, City departments administering environmental programs or enforcing legislation and other groups and individuals, including the general public" (City of Toronto Department of Public Health Memorandum, 1987). The establishment of this office illustrates the way in which departments can collaborate to meet common objectives and the revitalization of interest and activity in the environment of public health.

Haughton (1987) describes another interesting initiative in healthy public policy which is occurring in some American cities. Local food policies are being established to

...guide decision-making at each point of the food system, from the environmental resource base that provides the foods, to food production, to processing, distribution, transportation, and marketing, to consumer purchase and preparation of food, and ultimately to consumption as it relates to health and well-being (Haughton, 1987:181).

In Knoxville, Tennessee, the process of developing a food policy has involved the local government adopting a resolution on food policy thus making food policy an official responsibility of the civic government. Subsequently, a Food Policy Council with broad public and private representation was established to develop a plan to implement a municipal food policy. Voluntary Advisory Committees support the Food Policy Council with expertise in various areas such as nutrition and health and the food industry. Similar initiatives in food policy are under way in a number of other cities including Charleston, South Carolina; Kansas City, Missouri; Philadelphia, Pennsylvania; and St. Paul, Minnesota (Haughton, 1987). It will be interesting to follow the progress of these policies in the next few years, as the experiences gained may be of use in other cities and perhaps at other jurisdictional levels.

BARRIERS TO COORDINATION

There appears to be a variety of barriers to coordinating healthy public policy such as inexperience in working on a multisectoral basis and vested interest groups which may resist the opening up of policy-making to new stakeholders such as the elderly, the unemployed, members of minority groups and so on. This final section explores some of the barriers alluded to or made explicit in the literature on healthy public policy.

One alleged barrier is lack of political will; certainly political leadership is advocated in numerous documents (*Targets for Health for All*, 1985; *Toward a Shared Direction for Health in Ontario*, 1987). It is unclear whether this is an accurate portrayal of political realities. Nevertheless, leadership in the political arena is necessary, as fragmented, sometimes contradictory policies exist, though it is not clear that lack of political will is to blame for this state of affairs. Caution in alleging that political will is the primary barrier to healthy public policy is advisable.

Competing interests, such as those of industry and those of the public health sector, provide another significant barrier to coordinating healthy public policy. Efforts to collaborate among varied interests may be facilitated if stakeholders come to recognize their interdependence (Gray, 1985). Further, although healthy public policy does not aim to subsume all societal goals to the goal of health, there is a definite threat of this in the rhetoric. In some instances, policy may ultimately be decided in terms of other social priorities; the aim of healthy public policy is to at least make the health impact of such policies explicit.

The distribution of powers in Canada's federal system may also inhibit or complicate multisectoral action. Federal-provincial dialogue and cooperation will be important in ensuring that mutually supportive policies are enacted at the various levels of government.

Meeting the criterion that healthy public policy involves public participation in policy development and implementation also poses a challenge. Effective machinery for such participation appears to be in its infancy still.

How the media deals with initiatives in health promotion and healthy public policy can work to facilitate or inhibit implementation. While it is debatable that the media influence public opinion on issues, it is likely that the media play a role in agenda-setting, through the portrait given of various issues and the issues selected for coverage in the first place (Dror, 1986).

Another issue in coordinating healthy public policy is the tension between "top-down" and "bottom-up" approaches to policy development and implementation (Bennett, 1986; Farrant, 1986; Ashton et al., 1986). Both approaches have significant implications for the structures and mechanisms of coordination, hence they pose a challenge to effective collaboration.

Finally, "it is often said that health is too important to be left to a Ministry of Health" (Bennett, 1986:739). This version of the argument underlying the call for healthy public policy, namely, that the health care sector alone is unable to meet the challenge of equity in health, raises the most significant barrier of all to coordinating healthy public policy—how can it be accomplished? Lack of experience and knowledge as to how to go about this enormously complex task pose an important barrier to advancement in this field. Bennett (1986:737) claims that "maintaining or expanding intraministerial departments" is difficult, with the result that "vertical programmes continue". The literature in intra- and interorganizational theory suggests that more needs to be learned about the mechanisms of collaboration and the factors which facilitate and inhibit it than is presently known. Milio (1986b) insists that we need to "learn by doing" and also through sophisticated, ongoing policy analyses in various social and political climates. The following chapter outlines gaps in the literature on healthy public policy and some of their research implications.

SUMMARY

Healthy public policy implies multisectoral coordination. Our review suggests that coordination is defined in many ways. It is not, in fact, defined in Achieving Health for All (1986), although its implicit meaning strongly suggests collaboration. As such, coordination demands new approaches to policy development and implementation and new structures to support such efforts. One framework for analyzing developments in healthy public policy is proposed by Milio (1987a). She argues that three approaches to healthy public policy predominate: a targeted approach; a policy planning structures approach; and a participatory structures approach.

Targeted approaches are those which are aimed at a specific area of policy such as food and nutrition or car-

diovascular disease. Canada's recent development of a national program to reduce tobacco use is such an approach. Policy planning structures approaches are those in which mechanisms for intersectoral planning and policy development which span policy domains are developed. One example of this approach is the Interministerial Committee established as part of the Swedish health strategy for the 1990s. The participatory structures approach addresses healthy public policy from a different angle—the need for widespread public participation in the policy process. Milio (1987a) reports that Australia and New Zealand have emphasized this approach in developing women's health policies. Such a framework as this one of characterizing the major feature of an approach to healthy public policy is useful, although it is recognized that many countries have employed approaches which combine these strategies.

A number of barriers mitigate against effective collaboration. Lack of "political will", frequently invoked, often masks other barriers such as lack of cooperation by stakeholders with competing interests or at differing jurisdictional levels, difficulties in developing mechanisms to encourage public participation, inexperience in policy realms by interested participants, and a simple lack of basic knowledge on the part of anyone as to the most effective policy coordination mechanisms. In addition, philosophical or ideological differences between advocates of "top-down" and "bottom-up" approaches exacerbate implementation difficulties.

Research in interorganizational relations suggests that a number of conditions may facilitate the collaboration of multiple actors as is demanded by healthy public policy. Gray (1985) suggests that when stakeholders in a problem domain come to recognize their mutual interdependence, there is a greater likelihood of collaboration. Gray also suggests that if a legitimate, respected authority or stakeholder convenes the assembling of all stakeholders, collaboration is more likely. A third condition which may enhance collaboration is the shared perception among stakeholders that collaboration may lead to more favorable problem resolution than other methods of problem-solving such as litigation. This area of research may be valuable in attempts to foster coordination between various actors to ensure healthy public policy.

There is a growing body of literature on experiences in healthy public policy at all levels from national to local. In each instance, the problems of coordination are confronted although the literature explains how these problems are addressed more or less elaborately. Milio (1987a) provides a rich resource on the structural and procedural variations in healthy public policy around the world. Recent Canadian examples have also been described in this chapter. Research attention to such concrete examples of healthy public policy coordination would enrich our understanding of this process.

REFERENCES

Achieving Health for All: A Framework for Health Promotion. Ottawa: Health and Welfare Canada, 1986.

Aldrich, H. Resource dependence and interorganizational relations. *Administration and Society*, 7(4), 1976:419-454.

Ashford, D.E. The structural comparison of social policy and intergovernmental politics. *Policy and Politics*, 12(4), 1984:369-389.

Ashton, J., Grey, P. and Barnard, K. Healthy cities WHO's new public health initiative. *Health Promotion*, 1(2), 1986:129-133.

Ashton, J., Seymour, H., Ingledew, D., Ireland, R., Hopley, E., Parry, A., Ryan, M. and Holbourn, A. Promoting the new public health in Mersey. *Health Education Journal*, 45(3), 1986:174-179.

Bennett, F.J. Health revolution in Africa? *Social Science and Medicine*, 22(7), 1986:737-740.

Booth, T. Collaboration between the health and social services: Part I, a case study in joint care planning. *Policy and Politics*, 9(1), 1981:23-49.

Calnan, M. The politics of health: The case of smoking control. *Journal of Social Policy*, 13(3), 1984:279-296.

City of Toronto Department of Public Health. Memorandum to Board of Health concerning the Establishment of an Environmental Protection Office within the Department of Public Health. February 10, 1987.

DiStefano, T. Interorganizational conflict: a review of an emerging field. *Human Relations*, 37(5), 1984:351-366.

Dror, Yehezkel. *Policymaking Under Adversity*. New Brunswick, N.J.: Transaction Books, 1986.

Duhl, L.J. The healthy city: its function and its future. *Health Promotion*, 1(1), 1986b: 55-60.

Evans, Robert. A Retrospective on the "New Perspective". *Journal of Health Policy, Politics and Law*, 7(2), 1982:325-344.

Farrant, W. *"Health for All" in the Inner City*. Paddington and North Kensington Health Authority, London, 1986.

Fombrun, C.J. Structural dynamics within and between organizations. *Administrative Science Quarterly*, 31, 1986:403-421.

Fowler, G. Health education in general practice. *Health Education Journal*. 44(1), 1985:44-45.

Gray, B. Conditions facilitating interorganizational collaboration. *Human Relations*, 38(10), 1985:911-936.

Gray, B. and Hay, T.M. Political limits to interorganizational consensus and change. *The Journal of Applied Behavioural Science*, 22(2), 1986:95-111.

Hancock, Trevor. Beyond health care. *The Futurist*, August 1982:4-13.

Hancock, Trevor. Health in transition. *Canadian Home Economics Journal*, 35(1), 1985a:11-13, 16.

Hancock, Trevor. Lalonde and beyond: Looking back at "A New Perspective on the Health of Canadians". *Health Promotion*, 1(1), 1986a:93-100.

Hancock, Trevor. Personal interview. November 9, 1987a.

Hancock, Trevor. Healthy public policy in the Nordic countries: Preliminary report. *Canadian Journal of Public Health*, 78, Jan./Feb. 1987c:9-10.

Hancock, Trevor and Duhl, Leonard J. *Healthy Cities: Promoting Health in the Urban Context*. Background working paper for the "Healthy Cities Symposium", Lisbon, Portugal, April 7-11, 1986.

Harrison, L. and Tether, P. The co-ordination of UK policy on alcohol and tobacco: The significance of organizational networks. *Policy and Politics*, 15(2), 1987:77-90.

Haughton, B. Developing local food policies: One city's experiences. *Journal of Public Health Policy*, Summer 1987:180-191.

Health: A need for redirection. Toronto: Canadian Medical Association, Task Force on the Allocation of Health Care Resources, 1984.

Health for All 2000 and health promotion. Bloomsbury Health Authority, London, 1986.

Health for All Ontario. Report of the Panel on Health Goals for Ontario. August 1987.

Health in Sweden. Stockholm: The Swedish Ministry of Health and Social Affairs, 1982.

Health Promotion: Concept and Principles, in Action, A Policy Framework. Unpublished discussion document. Copenhagen: World Health Organization, Regional Office for Europe, 1986.

Health Promotion Matters in Ontario. Report of the Minister's Advisory Group on Health Promotion, 1987.

Healthy Toronto 2000. Toronto: Healthy Toronto 2000 Subcommittee, Board of Health, August 1987.

Intersectoral Action for Health. Geneva: World Health Organization, 1986.

Jaffe, E. The role of occupational therapy in disease prevention and health promotion. *The American Journal of Occupational Therapy*, 40(11), 1986:749-752.

Klepp, K-I. and Forster, J.L. The Norwegian nutrition and food policy: an integrated policy approach to a public health problem. *Journal of Public Health Policy*, December 1985:447-463.

Lalonde, M. *A New Perspective on the Health of Canadians*. Ottawa: Government of Canada, 1974.

Leppo, K. and Vertio, H. Smoking control in Finland: A case study in policy formulation and implementation. *Health Promotion*, 1(1), 1986:5-16.

Macpherson, A.S. Personal interview. November 18, 1987.

Malkas, T. Health effects of unemployment and national health policy in Finland. In G. Westcott, P.G. Svensson and H. Zollner (Eds.), *Health policy implications of unemployment*. Copenhagen: World Health Organization, Regional Office for Europe, 1985:357-368.

Milio, N. Promoting health through structural change: Analysis of the origins and implementation of Norway's farm-food-nutrition policy. *Social Science and Medicine*, 15A, 1981:721-734.

Milio, N. Commentary: Creating a Healthful Future. *Community Health Studies*, IX(3), 1985a:270-274.

Milio, N. Healthy nations: Creating a new ecology of public policy for health. *Canadian Journal of Public Health*, 76, Supplement 1, May/June 1985b:79-87.

Milio, N. *Promoting Health Through Public Policy*. Ottawa: Canadian Public Health Association, 1986a.

Milio, Nancy. Building healthy public policies: Focus for a new public health. Paper prepared for presentation at *An International Conference on Health Promotion: The Move Towards a New Public Health*, November 17-21, 1986b, Ottawa, Canada.

Milio, N. Multisectoral policy and health promotion: Where to begin? *Health Promotion*, 1(2), 1986c:129-132.

Milio, N. *Healthy Public Policy: Issues and Scenarios*. Unpublished paper prepared for A Symposium on Healthy Public Policy, Yale University, Oct. 5-6, 1987a.

Milio, N. Personal interview. October 28, 1987b.

Moran, G. Health promotion in local government: A British experience. *Health Promotion*, 1(2), 1986:191-200.

Mueller, K.J. Local implementation of national policy. *Policy Studies Review*, 4(1), 1984:86-98.

Pannenberg, Charles O. Scenarios as a method of probing and planning the future of health care. Paper prepared for the International Meeting on Future of Health and Health System in the Industrialized Societies, Bellagio, Italy, May 27-31, 1985.

Popham, G.T. Government and smoking: Policy-making and pressure groups. *Policy and Politics*, 9(3), 1981: 331-347.

A Proposal to Establish Health Objectives and Strategies for Canada. Discussion paper submitted by the Canadian Public Health Association with support and assistance from the Ontario Public Health Association, September 1985.

Rahim, M.A. A strategy for managing conflict in complex organizations. *Human Relations*, 38(1), 1985: 81-89.

Roemer, M.I. The value of medical care for health promotion. *American Journal of Public Health*, 74(3), 1984: 243-247.

(The) role of intersectoral cooperation in national strategies for Health for All. *Health Promotion*, 1(2), 1986:239-251.

Rootman, Irving. Personal correspondence. December 23, 1987.

Seymour, H., Ashton, J. and Edwards, P. Health museums or theme parks: a new approach to intersectoral collaboration. *Health Promotion*, 1(3), 1986: 311-317.

Shultz, J.M., Moen, M.E., Pechacek, T.F., Harty, K.C., Skubic, M.A., Gust, S.W. and Dean, A.G. The Minnesota plan for nonsmoking and health: The legislative experience. *Journal of Public Health Policy*, Autumn 1986: 300-313.

Squires, B.P. Medical education to achieve health for all. *Canadian Medical Association Journal*, 136, March 1, 1987:474-475.

Stahlberg, K. Local complexity and central bureaucracy in Finnish health care planning. *Journal of Health Politics, Policy and Law*, 8(3), 1983:444-462.

Targets for Health for All. Copenhagen: World Health Organization, Regional Office for Europe, 1985.

Tejada-de-Rivero, D.A. Meeting the challenge of health for all: The indispensable contribution of national public health associations. *Public Health Review*, 12, 1984:208-212.

Terris, M. Health promotion and disease prevention: What can medical schools contribute? *Forum*, XX(5), 1987:1-5.

Thompson, E.B., Hamrell, M. and Coffin, R.R. The Heart Healthy Vermonter Program. *Journal of Public Health Policy*, Spring 1987:36-43.

Tjosvold, Dean. The dynamics of interdependence in organizations. *Human Relations*, 39(6), 1986:517-540.

Toward A Shared Direction for Health in Ontario. Report of the Ontario Health Review Panel. June 1987.

Trist, E.L. Collaboration in work settings: A personal perspective. *Journal of Applied Behavioural Science*, 13(3), 1977:268-278.

Trist, E.L. Referent organizations and the development of interorganizational domains. *Human Relations*, 36(3), 1983:247-268.

Vienna Dialogue on "Health Policy and Health Promotion Towards a New Conception of Public Health". Copenhagen: World Health Organization, Regional Office for Europe. Unpublished document ICP/HSR 623, 1987.

(A) *Vision for A Healthy Ontario*. Paradigm Health. July 1986.

Vuori, H. Health for all and public health. *Canadian Journal of Public Health*, 76, Jan./Feb. 1985:13-16.

Weiss, J. Substance vs. symbol in administrative reform: the case of human services coordination. *Policy Analysis*, 7(1). 1981:21-45.

White, F. A voluntary perspective on health promotion the role of non-governmental organizations, particularly in the voluntary sector. *Canadian Journal of Public Health*, 77, Nov./Dec. 1986:431-436.

Wilkins, K.C. and Hoey, J.R. Who should promote health and provide preventive care? *Canadian Medical Association Journal*, 132, April 15, 1985:903-905.

Ziglio, E. "Uncertainty" in health promotion: Nutrition policy in two countries. *Health Promotion*, 1(3), 1986b:257-268.

Chapter Six

RESEARCH ON HEALTHY PUBLIC POLICY

The previous sections of this report have described and analyzed many of the central issues concerning the development, implementation and coordination of healthy public policy. Here, we examine the research implications of a focus on healthy public policy in terms of a) possible content areas for research, b) discussion of alternative designs for research and, c) various mechanisms to facilitate research in this area.

Albrecht and Johnson (1985) define policy research as, "empirical efforts designed either retrospectively to evaluate the impact of laws, regulations and programs on the quality of life of a population, or prospectively to construct a coherent plan that sets priorities and allocates resources to achieve goals." This definition has only limited usefulness for the types of research relevant to healthy public policy. It is limited in that it emphasizes the planning and evaluation of public policy in isolation from the social and political context which provides the policy environment. (Barrett and Hill, 1984; Wittrock and DeLeon, 1986). Research on healthy public policy may include elements of the above, but also requires innovative perspectives in terms of both the content and design of studies.

While there is much interest in the idea of research in healthy public policy (*Research in Health Promotion*, 1984; Attinger, 1985; Vuori, 1987), the literature does not currently indicate clear directions in this regard. There are many gaps in our present understanding of healthy public policy, several of which have been alluded to earlier in this report. While we know a great deal from the literature about the need for healthy public policy, we have little empirical evidence concerning the effects of various implementation and coordination strategies, the contexts of its development, or the effects of such policy on the health of populations.

In the face of such major gaps in knowledge, the following discussion offers some preliminary suggestions regarding the content of research, research design and mechanisms to facilitate research in healthy public policy.

CONTENT AREAS FOR RESEARCH IN HEALTHY PUBLIC POLICY

Based on the literature reviewed earlier in this report, a few content areas emerge as priorities for research in healthy public policy. These broad areas include the following:

- a) analyses concerning the theory underlying healthy public policy;
- b) examples of existing healthy public policy;
- c) studies of the feasibility of developing healthy public policy;
- d) studies of the effects of context upon implementation;
- e) studies of coordinating mechanisms;
- f) studies of the health effects of healthy public policy;
- g) studies identifying the indicators of healthy public policy.

Each of these areas will be discussed in turn.

Theory Underlying Healthy Public Policy

Much of the literature on healthy public policy contains implicit theoretical assumptions about social and political forces in the process of change. For example, the notion of shared vision is based essentially on a consensus model of change in which the various interest groups and social strata agree on fundamental societal values. A conflict theory of change, however, gives little credence to the notion of shared vision, arguing that ultimately decisions will be made in favour of the dominant interests in society.

Research is needed which examines the origins, manifestations and outcomes of healthy public policy from a theoretical perspective. Specific research questions might include the following:

- 1) Why is there an interest in healthy public policy in this particular period in history? What forces in society have determined that there is a problem in the first place?
- 2) What is the role of the state in conceptualizing, coordinating and evaluating healthy public policy?

- 3) Given the various social and political foci in society, is it possible to agree on a vision of a healthy society?
- 4) How can the problems of intersectoral cooperation be understood through the use of exchange theory or the notion of negotiated order?
- 5) Who are the "players" in the development and coordination of healthy public policy? What interest groups do they represent?
- 6) How can the "public good" be reconciled with individual interests in fostering healthy public policy?

Research of this type, like that described in the section on feasibility, will help to clarify the context within which healthy public policy exists. Thus, while it is important to develop studies on the content and process of healthy public policy itself, research on the context of its development is equally important.

Examples of Existing Healthy Public Policy

A recent review of some national examples of healthy public policy by Nancy Milio (1987a) summarizes the experiences of several countries in this area. Short précis of policy initiatives in Sweden, Finland, Ireland and the Netherlands, among others, provide up-to-date information on healthy public policy initiatives. It would be useful, however, to gather more extensive information about these examples, including a description of the political, social and economic climates which gave rise to such activities as well as descriptions and analyses of the organization and coordination of healthy public policy.

Of particular interest in studies of this type are examples of intersectoral and interjurisdictional collaboration in establishing healthy public policy. Another key issue to document in these studies is how community participation is included in the development and implementation of healthy public policy. A World Health Organization publication, *Planning and Management for Health* (1984), reports discussions of a European conference. It identifies two critical issues as how to achieve user or consumer participation and how to obtain a balance between centralization and decentralization in the health system. Research is almost entirely lacking with respect to these questions.

In addition to comparative studies on a national scale, more regional and local examples of healthy public policy are needed. One example of this type of study is what a recent WHO working group (*Research in Health Promotion*, 1984) referred to as a "policy audit study", relating to one of the priorities for the year 2000 to promote healthy public policy:

It is based on an independent audit of the development of (national, local) policies in a

non-health sector, e.g. food and housing, and investigates how these policies relate to knowledge of effects on health. The study would involve interviews with personnel involved in the development of policy, specifically their views on barriers and opportunities for the promotion of a more health-conducive (food and housing) policy and would seek to identify issues and strategies over which they felt they had little control. There is a need for a historical perspective, so policies should be analyzed retrospectively in order to identify and explore the values, interests and political constraints on policy development and on the activities of policy-makers.

Studies of the Feasibility of Developing Healthy Public Policy

It is probable that the development and coordination of healthy public policy is more feasible under certain social, economic and political conditions. The context within which healthy public policy is developed influences the degree to which it is effective (Graham and Graham, 1975; Frank, 1985; Barrett and Hill, 1984; Wittrock and deLeon, 1986). Graham and Graham (1975:263) use the term "macroanalysis" to describe the process which "clarifies the limitations which will invariably constrain and reduce available courses of public action". It may be found, for example, that healthy public policy is less likely to persevere in societies in which the pursuit of profit is dominant.

The type of study described above is important in that it identifies the underlying social and political structures of government which can facilitate or inhibit attempts to implement healthy public policy. Historical and case studies lend themselves quite well to the question of political feasibility.

Studies of the Effects of Context upon Implementation

Barrett and Hill (1984) urge that empirical studies of implementation raise questions about their context. In particular, they urge that issues about the structure of power—within a particular policy but also in terms of the wider social and political structure within which the particular is embedded—should be brought into implementation analysis. They are much less clear about how it should be done without enlarging research activities beyond the point of manageability. In their own work, however, they have emphasized not merely policy content, but also policy context.

We have tried to look behind the 'status quo' of current legal and administrative structures and rules, to focus specifically on questions of conflict, consensus and power; how values, interests, resources (including power) get used to establish or change the 'rules of the game'

as well as in the operation of the 'rules' in particular situations (Barrett and Hill, 1984:238).

Wittrock and DeLeon (1986) emphasize the importance of connecting studies of policy processes to political and societal macroanalyses in implementation research. They trace a tradition in policy analysis associated with H.D. Lasswell (1951; 1971) called problem-oriented scholarship. Lasswell advocated that the problem-orientation focus on the basic conflicts rather than upon issues of the moment. Such an analysis would be open to the contribution of a diversity of methods and be based on a contextual understanding of the larger social setting of the events studied, as well as their evolution over time. The initial steps they suggest toward "a mode of analysis of implementation process which combines policy relevance with conceptual realism" (Wittrock and DeLeon, 1986:55) are the development of a typology of policies in terms of a temporal framework; an increased, but carefully selective, reliance on strategies of adaptive implementation; and research to assess whether or not there exists logical or empirical evidence that new policy proposals would resolve their target problems.

Thain's (1987) proposed analytic framework for studying the implementation of economic policy explicitly includes the historical notion of the antecedents of policy and an environmental notion of wider societal influences. Sabatier (1986) proposes a framework for implementation research created from a synthesis of the strengths of the top-down and bottom-up approaches. Included in this framework is a focus on the effects of socio-economic and other changes external to the policy network on actors' resources and strategies.

As O'Toole (1986:202) summarizes,

...the field of implementation has yet to address, as part of its research strategy, the challenge of contextuality... beyond fairly empty injunctions for policy makers, implementers and researchers to pay attention to the social, economic, political and legal setting.

Attention to the context of policy is comparable to the policy research priorities identified by Milio (1987b). In relation to healthy public policy, Milio has recommended that policy be studied, with particular investigation of the 'social climate'. An investigation of the social climate would include attention to political economy on one hand, but also to the influence of the media on another. The investigation would assess the conditions that make new policies possible and effective or ineffective. What is it about the conditions that makes this a good or bad time to introduce a policy? Such research would assist, for example, in assessing the probability of healthy pub-

lic policy being placed on the political agenda, in judging the balance of interests facilitating or inhibiting its introduction, and in gauging the general feasibility and timing of implementation.

Studies of Coordinating Mechanisms

Central to the issue of coordinating healthy public policy is the question of how coordination is achieved and, specifically, the mechanisms to accomplish this. For example, is coordination best accomplished through a central coordinating body or is it possible to coordinate healthy public policy from the ground up? Furthermore, is there an inherent contradiction between the notion of coordinating healthy public policy and of broad-based community participation in its development? Research is needed simply to identify the decision-makers and resource-allocators, and the various "stakeholders" in the healthy public policy domains (Mark and Shotland, 1985).

Studies are also needed to clarify how various sectors collaborate in problem-solving related to health, the extent to which actors in the health sector are consulted by stakeholders in other sectors concerning the health implications of policy developments which are not explicitly health domains, and the extent to which such intersectoral consultation is reciprocated.

Studies of this type would include the identification and analysis of existing examples of coordination. Also, studies which involve the construction and testing of innovative models of coordination would be relevant. In this regard, there may be some value in considering a systems approach to modeling, including computer simulation (Dror, 1975).

The Health Effects of Healthy Public Policy

There is a need to evaluate the effects of healthy public policy on the health status of populations. While it may be difficult to quantify these effects in a scientifically rigorous way—healthy public policy does not lend itself to evaluation by randomized clinical trials—attempts should be made to establish health indicators which can be used to elucidate the relationship between healthy public policy and health status. Indicators of illness or pathology, such as morbidity indicators or disease-specific mortality rates, do play a part in the evaluation of healthy public policy initiatives, but cannot compensate for positive measures of health and well-being. In addition, indicators of phenomena not immediately identifiable as health phenomena, but theoretically tied to them in causal formulations, can be important in evaluation efforts.

Such studies might include the evaluation of policies with established objectives. For example, an inter-sectoral policy designed to reduce the amount of automobile exhaust by controlling traffic in the inner city could be evaluated by monitoring changes in carbon monoxide levels over time.

Indicators of Healthy Public Policy

In addition to measurement of the health effects of healthy public policy, there is a need to develop specific indicators of the presence of healthy public policy. According to Ziglio (1987), policy indicators "should provide guidance to decision makers." Indicators on the various phases of policy-making fulfill such tasks, Ziglio (1987b:3) states, as:

- 1) description of social organizations and institutions engaged in policy-making;
- 2) description of policy-making processes and outcomes;
- 3) indication of policy directions;
- 4) illustration of past, present and future trends.

The identification of indicators will make it possible to evaluate and analyze healthy public policy in various settings. Ziglio also suggests that indicators may vary under different social, political and cultural circumstances, i.e. from country to country. Thus, there may be a problem of making direct comparisons between the various countries engaged in the development of healthy public policy. Nevertheless, this problem is not unique to healthy public policy research, and the issues are sufficiently important to warrant the attempt.

DESIGN ISSUES IN RESEARCH ON HEALTHY PUBLIC POLICY

In addition to recognizing the importance of the several content areas described above, we need to explore the appropriateness of various research designs for the study of healthy public policy. We begin with the assumption that many of the usual designs for research on health may not be appropriate or feasible for studies in this area.

Three issues concerning research design will be examined here: a) the suitability of quantitative vs. qualitative approaches; b) the appropriateness of retrospective vs. prospective studies; and c) the role of "action research" for developing and evaluating healthy public policy.

Suitability of Quantitative Versus Qualitative Approaches

While much research in the social and behavioural sciences emphasizes the importance of quantitative studies of phenomena, the examination of healthy public policy may require alternative (or combined) approaches. In his detailed review of research in health behaviour, health promotion and public health, McQueen (1987) points out the limitations of quantitative analysis for the "new public health". McQueen believes that the public health researcher's preoccupation with quantitative methods is a reflection of its bio-medical orientation, the classic example being the application of epidemiology to study patterns of disease distribution. He suggests

that both quantitative and qualitative methods should be used in public health research:

Perhaps the fundamental problem is the continued acceptance of the view that there is a real, hard-fixed separation, instead of the shades of grey in the continuum between qualitative and quantitative methods.... If the ultimate goal of research is to reveal meaning, then it must slip easily back and forth from one approach to the other. (McQueen, 1987:12)

The kinds of qualitative methods which lend themselves to research in healthy public policy include historical analysis of the context of its development and in-depth interviewing of participants in the process of policy development. For example, research on the development and coordination of healthy public policy concerning tobacco production might include an historical analysis of the context of the problem, including an examination of the political economy of production and in-depth interviews with those involved, including policy makers and those affected by policy tobacco farmers, cigarette manufacturers and members of the public.

Quantitative methods are also necessary for research on healthy public policy. To extend the tobacco production example, data are needed to quantify original production output and production output following (legislative) change. It may also be possible to estimate the effect of changes in availability on consumption patterns, and to predict and document the eventual health outcomes of change.

Quantitative methods are particularly important to establish and assess indicators of healthy public policy. Recent developments, such as the healthy cities project (Ashton, Grey and Barnard, 1986), often lack specific objectives or measurable indicators of success. However, it may be possible to utilize existing or innovative indicators of a healthy city such as the amount of available green space or the pollution index.

Shortell (1982:691) recommends the use of multiple approaches for research on health policy, including both qualitative and quantitative methods. The term he uses for these approaches is, "triangulation" (from Denzin's work), which means, "...the use of a combination of multiple methods, data types, observers and theories in the same investigation". Research designs for the study of healthy public policy seem particularly suited to the use of "triangulation".

Appropriateness of Retrospective Versus Prospective Studies

In addition to the issue of quantitative vs. qualitative designs for research in healthy public policy, there is a further design question—should studies be retrospective or prospective? Retrospective studies of healthy public policy would consist of analyses of

existing policies, including an examination of the role of various sectors in developing policy, with an attempt to understand the relative success (or failure) of these policies. Prospective studies, conversely, would be undertaken at the beginning of policy initiatives, or even prior to their initiation, and would assess their effects over time.

Again, it appears that the issue does not necessarily require an either-or decision. It is likely that both retrospective and prospective studies of healthy public policy would provide useful information. Retrospective research, in the form of historical studies of healthy public policy, would offer insight into the feasibility of this type of research in particular settings (Graham and Graham, 1975). Prospective studies of healthy public policy can be envisioned as "reforms as experiments," in which the effects of specific policies are monitored over time to assess outcomes (both expected and unexpected) and processes (Berk, Boruch, Chambers, Rossi and Witte, 1985; Campbell, 1969).

An example of a retrospective design for research on healthy public policy would be studies of the political and historical context which gave rise to particular examples of healthy public policy, such as the factors influencing the City of Toronto's decision to legislate no-smoking sections in restaurants.

A prospective design might be exemplified by the tracking of attempts at implementing healthy public policy in various national, provincial and regional settings. Milio's (1987a) summary of international examples of healthy public policy could be developed into a formal, cross-cultural comparative study, using a prospective design. Within a given society, a prospective design might examine responsiveness across or within industrial sectors to healthy public policy initiatives. For example, in Canada, valuable lessons might be learned from prospectively tracking the response of airline and public transportation companies to public opinion and legislative changes concerning smoking.

Another type of prospective study would consist of projecting the effects of healthy public policy using simulation (Albrecht and Johnson, 1985). Information on various social, political, environmental and demographic factors could be analyzed, using computers, in an attempt to provide alternative scenarios with implications for health policy. Albrecht and Johnson (1985:286) explain this further:

Data collected for many different purposes under widely variant conditions can be integrated for making policy decisions. Meta-analysis and computer models are but two techniques for compiling massive amounts of information and making value judgments about the accumulated evidence.

Simulations can only be made on the basis of assumptions about factors affecting future trends and possible

changes in contextual factors and their impacts. They nonetheless constitute a useful methodology for describing possible futures. In contrast to simulations, futures research, which develops scenarios of possible alternative futures not necessarily seen as extensions of the present, are gaining favour.

The Role of "Action Research" in Healthy Public Policy

The notion of "Action Research" is not new, having been developed by Kurt Lewin in 1946 (Susman, 1978). It is described by Susman (1978:586) as "social research which combined generation of theory with changing the social system through the researcher acting on or in the social system". Of primary importance, in "action research", is participation of the affected population in the various stages of problem definition, data collection and interpretation. "Action research" is also future-oriented, with improvement of the social system as a basic goal. In this sense, it is compatible with the ideal of community participation in healthy public policy (Vuori, 1987).

Studies based on "action research" have a specific role to play in research on healthy public policy. The area in which this type of research might prove most useful is studies of the process whereby communities are involved in the generation of healthy public policy. "Action research" appears to have somewhat less to contribute in terms of further understanding of coordinating mechanisms for healthy public policy or for measuring the effects of this policy.

Having examined some potential content areas and design issues concerning research in healthy public policy, we now turn to the question of how to facilitate these types of research.

MECHANISMS TO FACILITATE RESEARCH IN HEALTHY PUBLIC POLICY

The primary mechanism whereby government can facilitate research on healthy public policy is to provide incentives for studies of this type. According to Shortell (1982), "the importance of the reward system, particularly for university-based researchers, is to create an incentive for relevant and useful policy research that can increase the probability that the results will have utility."

Shortell lists four mechanisms whereby research in public policy can be facilitated:

- 1) creating interdisciplinary training opportunities;
- 2) providing ongoing funding for research centres;
- 3) changing reward structures to support the above-mentioned activities;
- 4) promoting linkages between academic departments, policy research institutes and operational settings.

A number of these suggested mechanisms are relevant for facilitating research on healthy public

policy in Canada. Since the study of healthy public policy is, by nature, interdisciplinary, this type of research should be encouraged. One concrete way of supporting interdisciplinary research is to establish a Canadian centre for the study of health policy, attached to an existing university. Scholars from several different departments could then focus attention on issues related to healthy public policy.

Another incentive for government to use to facilitate research on healthy public policy is expanding the content areas for funding. For example, the National Health Research and Development Program (NHRDP) could establish as priorities studies dealing with cross-cultural examples of healthy public policy, studies of coordinating mechanisms, studies of the feasibility and of the health effects of healthy public policy. Support could also be offered on the basis of post-doctoral and career scientist awards for study on healthy public policy. Both NHRDP and the Social Science and Humanities Research Council of Canada (SSHRC) have demonstrated success with such approaches. In the "Strategic Grants Program" of SSHRC, for example, funds have been allocated for the first three activities described by Shortell: research centre funding, career development and incentives.

While expanding the range of research opportunities for scholars, it is important to maintain funding for more traditional studies, including studies of particular populations and the use of various health promotion and disease prevention strategies to enhance health and avoid disease. Thus, research funds for the study of healthy public policy may need to be added to existing funding programs.

It is critically important to signal the acceptability of a broad range of methodologies in such research. For example, true experiments, or even quasi-experimental designs, have limited utility in this area, while case studies, historical research, and focused, qualitative data-gathering approaches have wide utility. Because such approaches are not widely accepted in the biomedical research community, it is necessary for the health research community to legitimate them explicitly.

SUMMARY

In this section of the report, we have examined possible content areas for research on healthy public policy, the implications of these areas on research designs, and mechanisms to facilitate research on healthy public policy. Seven content areas were outlined, including: 1) analyses of the theory underlying healthy public policy; 2) examples of existing healthy public policy; 3) studies of feasibility; 4) studies of the effects of context upon implementation; 5) studies of coordinating mechanisms; 6) studies of the health effects of healthy public policy; and 7) studies identifying indicators of the presence of healthy public policy.

Three design issues were discussed. It was proposed that both quantitative and qualitative designs are appropriate, that both retrospective and prospective studies are needed, and that "action research" may be useful in studies examining the role of community participation in policy.

Research in healthy public policy can be facilitated by providing incentives to researchers through the establishment of inter-disciplinary centres of research, through career development initiatives and other incentives, and by creating funding priorities compatible with this type of research.

REFERENCES

- Albrecht, G. and Johnson, D. The Social Context of Policy Research. *Sociological Methods and Research*, 13(3), Feb., 1985:275-287.
- Ashton, J., Grey, P., Barnard, K. Healthy Cities WHO's New Public Health Initiative. *Health Promotion*, 1(2), 1986:129-133.
- Attinger, E. Dynamic Modeling and Health Policy Research. Methodological Foundations for Research on the Determinants of Health Development, Proceedings of an Informal Consultation, Geneva: World Health Organization, 1985.
- Barrett, Susan and Hill, Michael. Policy, bargaining, and structure in implementation theory: Towards an integrated perspective. *Policy and Politics*, 12(3), 1984:219-240.
- Berk, R., Boruch, R., Chambers, D., Rossi, P. and Witte, A. Social Policy Experimentation: A Position Paper. *Evaluation Review*, 9(4), August 1985:387-429.
- Campbell, D. Reforms as Experiments. *American Psychologist*, 24(4), 1969:409-429.
- Dror, Yehezkel. Some Features of a Meta-model for Policy Studies. *Policy Studies Journal*, 3(3), Spring 1975:247-255.
- Frank, J. Public Health Policy and the Quality of Epidemiological Evidence: How Good Is Good Enough?. *Journal of Public Health Policy*, Sept. 1985:314-321.
- Graham, G. and Graham, S. Macroevaluation: Framework for a Policy System. *Policy Studies Journal*, 3(3), 1975:262-268.
- Lasswell, H. D. The policy orientation. In D. Lerner and H.D. Lasswell (eds.), *The Policy Sciences*. Stanford, CA: Stanford University Press, 1951:3-15.
- Lasswell, H.D. *A Preview of the Policy Sciences*. New York: American Elsevier, 1971.
- Mark, M. and Shotland, R. Stakeholder-based Evaluation and Value Judgments. *Evaluation Review*, 9, 1985:605-625.
- McQueen, D. Research in Health Behaviour, Health Promotion, and Public Health. Unpublished paper, 1987.

Milio, Nancy. Healthy Public Policy: Issues and Scenarios. Paper prepared for a symposium on Healthy Public Policy, Yale University, Oct. 5-6, 1987a.

Milio, Nancy. Personal interview, October 28, 1987b.

O'Toole, Laurence J. Policy recommendations for multi-actor implementation: An assessment of the field. *Journal of Public Policy*, 6(2), 1986:181-210.

Planning and Management for Health. Report on a European conference, The Hague, 27 August 1 September, 1984. Euro Reports and Studies 102. Copenhagen: World Health Organization, Regional Office for Europe, 1984.

Research in Health Promotion: Priorities, Strategies, Barriers. World Health Organization. Report on a joint WHO/SHEG workshop, Edinburgh, Nov. 5-7, 1984.

Sabatier, Paul A. Top-down and bottom-up approaches to implementation research: A critical analysis and suggested synthesis. *Journal of Public Policy*, 6(1), 1986:21-48.

Shortell, S. Improving Health Care Policy Research. *Journal of Health Politics, Policy and Law*, 6(4), 1982:681-701.

Susman, G. and Evered, R. An Assessment of the Scientific Merits of Action Research. *Administrative Science Quarterly*, 23, December 1978:582-603.

Thain, Colin. Implementing economic policy: An analytical framework. *Policy and Politics*, 15(2), 1987:67-75.

Vuori, H. WHO A Source of Inspiration for Researchers?. *Scandinavian Journal of Social Medicine*, 15, 1987:57-61.

Wittrock, Bjorn and DeLeon, Peter. Policy as a moving target: A call for conceptual realism. *Policy Studies Review*, 6(1), 1986:44-60.

Ziglio, Erio. Health Policy Study: Stimulus Protocol. Stimulus paper prepared for WHO meeting on health promotion research, October 4-6, 1987b, Edinburgh, Scotland.

COORDINATING HEALTHY PUBLIC POLICY BIBLIOGRAPHY

CANADIAN DEVELOPMENTS IN HEALTH PROMOTION:

Brunet, J., Dillard, S., Brunelle, Y. and Blanchet, M. Health objectives for Quebec. Unpublished paper. May 14, 1985.

Chenoy, N.C. Health Promotion. Notes for a presentation to Action Centre Conference (1986), Hamilton, Ontario, October 4, 1986.

Directional paper of the national program to reduce tobacco use in Canada. National Program to Reduce Tobacco Use, June 1987.

Foster, P. Health board heal thyself. *The Financial Post*, November 16, 1987:14.

Hancock, T. *Creating environments for health.* Background paper prepared for An International Conference on Health Promotion: The Move Towards A New Public Health, November 17-21, Ottawa, Ont., 1986b.

Health and Welfare Canada. Federal directorate spotlights promotion and prevention. *Health Education*, 17(4), 1979:11.

Health and Welfare Canada. Organizational changes in the Department of National Health and Welfare. *Health Education*, 17(3), 1978:12.

Health for All Ontario. Report of the Panel on Health Goals for Ontario. August 1987.

Health Promotion Matters in Ontario. Report of the Minister's Advisory Committee on Health Promotion, 1987.

Korn, D. and Conway, J. *Making gains in health through health promotion.* Paper prepared for Second Annual Conference on Health Care in Canada, Wilfrid Laurier University, May 1, 1987.

Labonte, R. and Penfold, S. Canadian perspectives in health promotion: A critique. *Health Education*, April 1981:4-9.

Laframboise, H.L. Health policy: breaking the problem down into more manageable segments. *Canadian Medical Association Journal*, February 3, 1973, 178:388-393.

Lalonde, Marc. *A New Perspective on the Health of Canadians.* Ottawa: Government of Canada, 1974.

Long-term Goals and Objectives for Health in Ontario. Mission statement of the Ontario Council of Health, August 1983.

McWhinney, I.R. Fine words, but will he deliver? *Canadian Medical Association Journal*, 36, March 1, 1987:473-474.

Mustard, J.F. "Achieving Health for All": implications for Canadian health and social policies. *Canadian Medical Association Journal*, 136, March 1, 1987:471-473.

Niblett, D. Health promotion: a rediscovered social imperative? *Canadian Journal of Public Health*, 66, Sept./Oct. 1975:357-358.

Objectif Santé. Rapport du comité d'étude sur la promotion de la santé. Québec: Conseil des affaires sociales et de la famille, 1984.

Objective: A Health Concept in Quebec. A Report of the Task Force on Health Promotion. Translated by M.S. Gayk. Ottawa: Canadian Hospital Association, 1986.

Ontario Ministry of Health. *Health Care: The 80s and Beyond.* December 1983.

Rootman, Irving. Development of a national health promotion survey: The Canadian experience. *Health Promotion*, 1(3), 1986:393-399.

Rootman, Irving. Personal correspondence, December 23, 1987.

Ruderman, A.P. Marketing health promotion in Canada: an idea whose time has come. *Canadian Journal of Public Health*, 77, Sept./Oct. 1986:315-317.

Six Program Priorities for a Healthier Alberta by 1990 and 1995. A discussion document. Prepared for the Joint Long Range Planning Steering Committee of the Health Unit Association of Alberta, March 1985.

Squires, B.P. Medical education to achieve health for all. *Canadian Medical Association Journal*, 136, March 1, 1987:474-475.

Stephens, T. Healthy lifestyles for all by the year 2000: how are Canadians doing? *Health Promotion*, Fall 1985:2-6.

Strengthening Community Health Means Strengthening Communities. Draft report. Canadian Public Health Association. Ottawa, Ontario, 1987.

Toward A Shared Direction for Health in Ontario. Report of the Ontario Health Review Panel. June 1987.

CANADIAN DEVELOPMENTS IN HEALTHY PUBLIC POLICY:

Glynn, P. and Edwards, P. *An Ecological Framework for Health Policy: The Canadian Experience.* (In press).

Pinder, Lavada. *Healthy Public Policy*. Unpublished working notes. June 18, 1987.

Pinder, Lavada. Healthy public policy in Canada. Presentation at *Other Voice*, The Canadian Institute of Planners, National Conference, Toronto, July 5-8, 1987.

Ziglio, E. "Uncertainty" in health promotion: Nutrition policy in two countries. *Health Promotion*, 1(3), 1986b:257-268.

COORDINATION:

Aldrich, H. Resource dependence and interorganizational relations. *Administration and Society*, 7(4), 1976:419-454.

Ashford, D.E. The structural comparison of social policy and intergovernmental politics. *Policy and Politics*, 12(4), 1984:369-389.

Booth, T. Collaboration between the health and social services: Part I, a case study in joint care planning. *Policy and Politics*, 9(1), 1981:23-49.

Booth, T. Collaboration between the health and social services: Part II, a case study in joint finance. *Policy and Politics*, 9(2), 1981:205-226.

DiStefano, T. Interorganizational conflict: a review of an emerging field. *Human Relations*, 37(5), 1984:351-366.

Fombrun, C.J. Structural dynamics within and between organizations. *Administrative Science Quarterly*, 31, 1986:403-421.

Gray, B. Conditions facilitating interorganizational collaboration. *Human Relations*, 38(10), 1985:911-936.

Gray, B. and Hay, T.M. Political limits to interorganizational consensus and change. *The Journal of Applied Behavioural Science*, 22(2), 1986:95-111.

Harrison, L. and Tether, P. The co-ordination of UK policy on alcohol and tobacco: The significance of organizational networks. *Policy and Politics*, 15(2), 1987:77-90.

Malkas, T. Health effects of unemployment and national health policy in Finland. In G. Westcott, P.G. Svensson and H. Zollner (Eds.), *Health policy implications of unemployment*. Copenhagen: World Health Organization, Regional Office for Europe, 1985:357-368.

Moran, G. Health promotion in local government: A British experience. *Health Promotion*, 1(2), 1986:191-200.

Mueller, K.J. Local implementation of national policy. *Policy Studies Review*, 4(1), 1984:86-98.

Nixon, J. Communication, co-ordination and implementation. *Policy and Politics*, 10(2), 1982:139-161.

Raadschelders, J.C.N. Coproduction in the fight against youth unemployment. *Planning and Administration*, 1, 1986:14-24.

Rahim, M.A. A strategy for managing conflict in complex organizations. *Human Relations*, 38(1), 1985:81-89.

Stahlberg, K. Local complexity and central bureaucracy in Finnish health care planning. *Journal of Health Politics, Policy and Law*, 8(3), 1983:444-462.

Trist, E.L. Collaboration in work settings: A personal perspective. *Journal of Applied Behavioural Science*, 13(3), 1977:268-278.

Trist, E.L. Referent organizations and the development of interorganizational domains. *Human Relations*, 36(3), 1983:247-268.

Vredenburg, D.J. and Maurer, J.G. A process framework of organizational politics. *Human Relations*, 37(1), 1984:47-66.

Weiss, J. Substance vs. symbol in administrative reform: the case of human services coordination. *Policy Analysis*, 7(1), 1981:21-45.

ECOLOGY OF POLICY:

Cox, Andrew. On the role of the state in urban policy-making: the case of inner-city and dispersal policies in Britain. In Valdo Pons and Ray Francis (eds.), *Urban Social Research: Problems and Prospects*. London: Routledge and Kegan Paul: 31-65.

Duhl, L.J. *Health planning and social change*. New York: Human Sciences Press Inc., 1986.

Elias, W.S. and Murphy, R.J. The case for health promotion programs containing health care costs: a review of the literature. *The American Journal of Occupational Therapy*, 40(11), 1986:659-763.

Emery, Fred. Cities, markets and civilized work, Anno 2000. *Human Relations*, 38(12), 1985b:1101-1112.

Fox, D.M. The consequences of consensus: American health policy in the twentieth century. *Milbank Quarterly*, 64(1), 1986:76-99.

Ginzberg, E. The delivery of health care: what lies ahead? *Inquiry*, XX Fall, 1983: 201-217.

Gough, Ian. *The Political Economy of the Welfare State*. London: MacMillan Press, 1979.

Hancock, T. Health in transition. *Canadian Home Economics Journal*, 35(1), 1985:11-13, 16.

Hatcher, G.H. Canadian approaches to health policy decisions—national health insurance. *American Journal of Public Health*, 68(9):881-889.

Hessler, Richard M. and Twaddle, Andrew C. Power and change: primary health care at the

crossroads in Sweden. *Human Organization*, 45(2), 1986:134-147.

Hill, Robert C. Market, state and community: national urban policy in the 1980s. *Urban Affairs Quarterly* 19(1), 1983:5-20.

Hueglin, T.O. The politics of fragmentation in an age of scarcity: a synthetic view and critical analysis of the welfare state crisis. *Canadian Journal of Political Science*, XX(2), June 1987:235-264.

de Kervasdoué, Jean, Kimberly, John R. and Rodwin, Victor G. (eds.). *The End of an Illusion: The Future of Health Policy in Western Industrialized Countries*. Berkeley: University of California Press, 1984.

Khakee, Abdul and Dahlgren, Lars. Values in futures studies and long term planning. *Futures*, 18(1), 1986:52-67.

McKnight, John. Professionalized service and disabling help. In I. Illich (ed.), *Disabling Professions*. Toronto: Burns and MacEachern, 1977:69-91.

Meilicke, Carl and Storch, Janet L. (eds). *Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends*. Ann Arbor, Michigan: Healthy Administration Press, 1980.

Meyer, Jack A. and Ein, Marion, (eds). *Charting the Future of Health Care*. Washington: American Enterprise Institute for Public Policy Research, 1986.

Milio, Nancy. Commentary: Creating a healthful future. *Community Health Studies*, IX(3), 1985a:270-274

Mustard, J. Fraser. *Achieving Health for All: Implications for Canadian health and social policies*. *Canadian Medical Association Journal*, 136, March 1, 1987:471-473.

Naisbitt, John. *Megatrends*. New York: Warner Books, Inc., 1982.

Navarro, Vincente. The crisis of the international capitalist order and its implications for the welfare state. *International Journal of Health Services*, 12(2), 1982:169-190.

Robbins, Anthony. Public health in the next decade. *Journal of Public Health Policy*, December 1985:440-446.

Robertson, James. *The Sane Alternative: A Choice of Futures*. St. Paul, Minnesota: River Basin Publishing Company, 1978.

Rosenthal, Marilyn M. Beyond equity: Swedish health policy and the private sector. *Milbank Quarterly*, 64(4), 1986:592-621.

Russell, L.B. The economics of prevention. *Health Policy*, 4, 1984:85-100.

Schon, Donald A. *Beyond the Stable State*. New York: W.W. Norton and Company, 1971.

Schwartz, Peter and Ogilvy, James. The emergent paradigm: Changing patterns of thought and belief. Analytical Report #7, Values and Lifestyles Program, 333 Ravenswood Avenue, Menlo Park, CA 94025, 1979.

Segall, Malcolm. On the concept of a socialist health system: A question of Marxist epistemology. *International Journal of Health Services*, 13(2), 1983: 221-225.

Waitzkin, Howard. Health policy and social change: A comparative history of Chile and Cuba. *Social Problems*, 31(2), 1983: 235-248.

Wallerstein, Immanuel. Economic cycles and socialist policies. *Futures*, 16(6), 1984:579-585.

Weller, G.R. The determinants of Canadian health policy. *Journal of Health Politics, Policy and Law*, 5(3), 1980:405-418.

Weller, G.R. The push for reprivatization of health care services in Canada, Britain and the United States. *Journal of Health Policy, Politics and Law*, 8(3), 1983:495-518.

White, N.F. *Future Models for the Health Field*. Paper prepared for Session 1411, Models for the Future of the Health Sciences, of the First Global Conference on the Future, July 24, 1980.

FRAMEWORKS:

Achieving Health for All: A Framework for Health Promotion. Ottawa: Health and Welfare Canada, 1986.

Clements, Paul. A conceptual framework for analyzing, managing and evaluating village development projects. *Sociologia Ruralis* XXVI(2), 1986:128-145.

Draper, Ron. Framework for healthy public policy. Unpublished mimeograph, 1987b.

Health Promotion: Concept and Principles, in Action, A Policy Framework. Unpublished discussion document. Copenhagen: World Health Organization, Regional Office for Europe, 1986.

Milio, Nancy. Toward a framework for healthy public policies. Unpublished paper from a World Health Organization seminar, Amsterdam, December 7-14, 1985c.

HEALTH FOR ALL MOVEMENT:

Achieving Health for All: A Framework for Health Promotion. Ottawa: Health and Welfare Canada, 1986.

Asvall, J.E. Towards a European policy in health. *Health policy*, 6, 1986:221-226.

De Jong, G.A. and Rutten, F.F.H. Justice and health for all. *Social Science and Medicine*, 17(16), 1983:1085-1095.

Duhl, L.J. The healthy city: its function and its future. *Health Promotion*, 1(1), 1986b: 55-60.

Farrant, Wendy. Health for All in the Inner City. Proposed Framework for a Community Development Approach to Health Promotion Policy and Planning at District Level. District Health Promotion Group, Paddington and North Kensington Health Authority, 1986.

Health Education and Promotion in Victoria. Report to the Minister of Health, June 1986.

Health for All by the Year 2000. Plan of Action for the implementation of regional strategies. Washington, D.C.: Pan American Health Organization, 1982.

Health for All 2000 and health promotion. Bloomsbury, London: Bloomsbury Health Authority, 1986.

Hellberg, H. Health for all and primary health care in Europe. *Public Health*, 101, 1987:151-157.

Isacson, S-O. Health for All in Europe. *Scandinavian Journal of Social Medicine*, 4(13), 1985:135-136.

Mahler, H. The meaning of "health for all by the year 2000". *World Health Forum*, 2(1), 1981:5-22.

Mahler, H. Address by the Director General of the World Health Organization at the opening ceremony of the International Conference on Health Promotion in Industrialized Countries. *Canadian Journal of Public Health*, 77, Nov./Dec. 1986:387-389.

Monekesso, G.L. A functional breakdown of the goal of "Health for All by the Year 2000". *West Indian Medical Journal*, 33(3), 1984: 140-145.

Navarro, V. A critique of the ideological and political position of the Brandt Report and the Alma Ata declaration. *International Journal of Health Services*, 14(2), 1984:159-172.

Ottawa Charter for Health Promotion. World Health Organization, Health and Welfare Canada, Canadian Public Health Association. November 1986.

The role of intersectoral cooperation in national strategies for Health for All. Report of the Technical Discussions at the 1986 World Health Assembly. *Health Promotion*, 1(2), 1986:239-251.

Rosdahl, N. Health for All by the Year 2000. Nordic responsibilities and potential approaches. *Scandinavian Journal of Social Medicine*, 4(13), 1985:133-134.

Strong, P.M. A new-modelled medicine? Comments on the WHO's Regional Strategy for Europe. *Social Science and Medicine*, 22(2), 1986:193-199.

Targets for Health for All. Copenhagen: World Health Organization, European Regional Office, 1985.

Vuori, H. Health for All and public health. *Canadian Journal of Public Health*, 76, Jan/Feb 1985:13-16.

HEALTH PLANNING:

Blum, Henrik L. *Planning for Health: Generics for the Eighties*. New York: Human Sciences Press, 1981.

DeSario, Jack. Demise of health planning in the United States: The politics of incremental health policy formation. *Journal of Public Health Policy*, June 1982: 164-177.

Duhl, Leonard. *Health Planning and Social Change*. New York: Human Sciences Press, 1986a.

Dumoulin, Jerome. Representations used for health planning: Naivety and crisis in the concepts and methods. *Health Policy* 5, 1985:199-205.

Nutt, Paul C. *Planning Methods for Health and Related Organizations*. New York: John Wiley and Sons, 1984.

Pannenberg, Charles O., van der Werff, Albert, Hirsch, Gary B. and Barnard, Keith (eds.). *Re-orienting Health Services: Application of a Systems Approach*. New York: Plenum Press, 1984.

Planning and management for health. Copenhagen: World Health Organization, Regional Office for Europe, 1984.

Reeves, Philip N., Bergwall, David F. and Woodside, Nina B. *Introduction to Health Planning*. Arlington, VA: Information Resources Press, 1984.

HEALTH POLITICS:

Alford, Robert. *Health Care Politics: Ideological and Interest Group Barriers to Reform*. Chicago: University of Chicago Press, 1975.

Baggot, Rob. Alcohol, politics and social policy. *Journal of Social Policy* 15(4), 1986:467-488.

Blum, Linda M. Politics and policy-making: The comparable worth debate. *Berkeley Journal of Sociology*, XXXVIII, 1983:39-67.

Calnan, Michael. The politics of health: The case of smoking control. *Journal of Social Policy*, 13(3), 1984:279-296.

Fontana, Leonard. Clique formation in a regional health planning agency. *Human Relations*, 38(9), 1985:895-910.

Fontana, Leonard. Political ideology and local health planning in the United States. *Human Relations*, 39(6), 1986:541-556.

Klein, Rudolf. The politics of ideology versus the ideology of politics: The case of Britain's National

Health Service in the 1980s. *The Milbank Memorial Fund Quarterly*, 62(1), 1984:82-102.

Koplin, Allen N. The politics of public health decision-making. *Journal of Public Health Policy*, September 1985:329-334.

Litman, Theodor J. and Robins, Leonard S. (eds.). *Health Politics and Policy*. New York: John Wiley and Sons, 1984.

McKnight, J. Politicizing health care. In Peter Conrad and Rochelle Kern (eds.). *The Sociology of Health and Illness, Critical Perspectives*, 2nd Edition. New York: St. Martin's Press, 1986:412-416.

O'Neill, M. A perspective on politics and health education policies. *Health Promotion*, January 1980:4-6, 9.

O'Neill, Michel. Les contraintes imposées par les facteurs politiques aux interventions gouvernementales en promotion de la santé. Draft, 1987. To appear in *Hygie* 4(4), 1987.

Popham, G.T. Government and smoking: Policy-making and pressure groups. *Policy and Politics*, 9(3), 1981: 331-347.

Pross, Paul. *Pressure Group Behaviour in Canadian Politics*. Scarborough, Ontario: McGraw-Hill Ryerson, 1975.

Taylor, R.C.R. The politics of prevention. *Social Policy*, Summer 1982:32-41.

Tesh, S. Disease causality and politics. *Journal of Health Politics, Policy and Law*, 6(3), 1981:369-390.

Tierney, John T. Organized interests in health politics and policy-making. *Medical Care Review* 44(1), 1987: 89-118.

HEALTH PROMOTION:

Allison, Kenneth R. Health education: self-responsibility vs. blaming the victim. *Health Education*, Spring 1982:11-13, 24.

Cowley, J. When health promotion works, the opposition begins: a personal view. *Health Promotion*, 1(2), 1986:201-209.

Crawford, Robert. You are dangerous to your health: the ideology and politics of victim blaming. *International Journal of Health Services*, 7, 1977:663-680.

Draper, Ron. Informal lecture given at Health and Welfare Canada, September 22, 1987a.

Health Promotion: Concept and Principles, in Action, A Policy Framework. Unpublished discussion document. Copenhagen: World Health Organization, Regional Office for Europe, 1986.

Health Promotion: Concepts and Principles. Unpublished working papers presented at the Working

Group on Concepts and Principles, Copenhagen, 9-13 July, 1984.

Health Promotion Glossary. D. Nutbeam, (Ed.). Copenhagen: World Health Organization, Regional Office for Europe. July 1985.

Kickbusch, Ilona. Involvement in health: a social concept of health education. *International Journal of Health Education*, Supplement to XXIV, Issue 3, Oct./Dec. 1981:2-15.

Kickbusch, Ilona. Health promotion: A typology. *Health Promotion: Concepts and Principles*, A selection of papers presented at the Working Group on Concepts and Principles, Copenhagen, 9-13 July, 1984. Unpublished material received from World Health Organization, Regional Office for Europe.

Kickbusch, Ilona. Health promotion: A global perspective. *Canadian Journal of Public Health*, 77, Sept./Oct. 1986:321-326.

Kickbusch, I. Issues in health promotion. *Health Promotion*, 1(4), 1987:437-442.

Labonte, R. and Penfold, S. *Health Promotion Philosophy*. Vancouver: Western Regional Office, Health Promotion Directorate, Health and Welfare Canada, 1981.

Lifestyles and Their Impact on Health. Copenhagen: World Health Organization, Regional Office for Europe. Unpublished technical document EUR/RC33/Tech.Disc./1, 1982.

Love, Rhonda and Kalnins, Ilze. Individualist and structuralist perspectives on nutrition education for Canadian children. *Social Science and Medicine*, 18(3), 1984:199-204.

McKeown, Thomas. *The Role of Medicine: Dream, Mirage or Nemesis?* London: Nuffield Provincial Hospitals Trust, 1976.

McKnight, J.L. Well-being: The new threshold to the old medicine. *Health Promotion*, 1(1), 1986:77-80.

Player, D. Health education and health promotion a positive approach. *Journal of the Royal Society of Medicine*, 79, Supplement 13, 1986:2-4.

Research in health promotion: priorities, strategies, barriers. Copenhagen: World Health Organization, Regional Office for Europe. Unpublished document ICP/HSR 601/m01, 1984.

Ryan, William. *Blaming the Victim*. New York: Pantheon, 1971.

Terris, M. What is health promotion? *Journal of Public Health Policy*. 7(2), 1986:147-151.

Vienna Dialogue on "Health Policy and Health Promotion Towards a New Conception of Public Health". Copenhagen: World Health Organization, Regional

Office for Europe. Unpublished document ICP/HSR 623, 1987.

Williams, G. Health promotion caring concern or slick salesmanship? *Journal of Medical Ethics*, 10, 1984:191-195.

HEALTHY PUBLIC POLICY:

Beyond health care: Proceedings of a conference on healthy public policy. *Canadian Journal of Public Health*, 76, Supplement 1, May/June 1985.

Buck, C. Beyond Lalonde creating health. *Canadian Journal of Public Health*, 76, Supplement 1, May/June 1985:19-24.

Draper, Ron. Informal lecture given at Health and Welfare Canada, September 22, 1987a.

Emery, Fred. Public policies for healthy workplaces. *Canadian Journal of Public Health*, 76, Supplement 1, May/June 1985a:46-50.

First Announcement. Healthy Public Policy, 2nd International Conference on Health Promotion, April 5-10, 1988, Adelaide, South Australia. Copenhagen: World Health Organization, Regional Office for Europe, May 6, 1987.

Hancock, Trevor. Beyond health care. *The Futurist*, August 1982:4-13.

Hancock, Trevor. Creating environments for health. Background paper prepared for An International Conference on Health Promotion: The Move Towards a New Public Health, Ottawa, Ontario, November 1986b.

Hancock, Trevor. Personal interview, November 9, 1987a.

Health Promotion: Concept and Principles, In Action, A Policy Framework. Unpublished discussion document. Copenhagen: World Health Organization, Regional Office for Europe, 1986.

Healthy Public Policy - Strategies for Action: The Adelaide Recommendations. World Health Organization, 1988.

Hetherington, Robert W. and Calderone, Gerald E. Prevention and health policy: A view from the social sciences. *Public Health Reports*, 100(5):507-514.

Intersectoral Action for Health. The role of intersectoral cooperation in national strategies for health for all. Geneva: World Health Organization, 1986.

Labonte, R. Social inequality and healthy public policy. *Health Promotion*, 1(3), 1986:341-351.

Milio, Nancy. Commentary: Creating a Healthful Future. *Community Health Studies*. IX(3), 1985a:270-274.

Milio, Nancy. Healthy nations: Creating a new ecology of public policy for health. *Canadian Journal of Public Health*, 76, Supplement 1, May/June 1985b:79-87.

Milio, Nancy. *Towards a Framework for Health-Promoting Public Policies.* Unpublished paper prepared for a WHO Seminar, Amsterdam, Dec. 7-14, 1985c.

Milio, Nancy. *Promoting Health Through Public Policy.* Ottawa: Canadian Public Health Association, 1986a.

Milio, Nancy. *Building Healthy Public Policies: Focus for a New Public Health.* Unpublished paper prepared for An International Conference on Health Promotion: The Move Towards A New Public Health, November 17-21, Ottawa, Ont., 1986b.

Milio, Nancy. Multisectoral policy and health promotion: where to begin? *Health Promotion*, 1(2), 1986c:129-132.

Milio, Nancy. *Healthy Public Policy: Issues and Scenarios.* Unpublished paper prepared for A Symposium on Healthy Public Policy, Yale University, Oct. 5-6, 1987a.

Milio, Nancy. Personal interview, October 28, 1987b.

Planning and management for health. Copenhagen: World Health Organization, Regional Office for Europe, 1984.

Reports of the sub-plenary sessions. Healthy public policy. *Health Promotion*, 1(4), 1987:447-448.

Vienna Dialogue on "Health Policy and Health Promotion Towards a New Conception of Public Health". Copenhagen: World Health Organization, Regional Office for Europe. Unpublished document ICP/HSR 623, 1987.

IMPLEMENTATION:

Barer, Morris L., Evans, Robert G., Stoddart, Greg L., Labelle, Roberta and Fulton, Jane. Lifestyles, linkages and liabilities: Theory and evidence justifying economic incentives for healthier lifestyles. Program for Quantitative Studies in Economics and Population, Faculty of Social Sciences, McMaster University, Hamilton, Ontario. QSEP Research Report No. 112, 1984.

Barrett, Susan and Hill, Michael. Policy, bargaining and structure in implementation theory: Towards an integrated perspective. *Policy and Politics* 12(3). 1984:219-240.

Bowen, Elinor R. The Pressman-Wildavsky paradox: Four addenda, or why methods based on probability theory can predict implementation success and suggest useful tactical advice implementers. *Journal of Public Policy*, 3(4). 1982:1-22.

Hambleton, Robin. Planning systems and policy implementation. *Journal of Public Policy*, 3(4), 1983:397-418.

Health for All by the Year 2000. Plan of Action for the implementation of regional strategies. Washington, D.C.: Pan American Health Organization, 1982.

Lane, J-E. Institutional innovation and implementation: The case of Sweden. *Policy Studies Journal*, 14(3), 1986:470-477.

Linder, Stephen H. and Peters, B. Guy. A design perspective on policy implementation: The fallacies of misplaced prescription. *Policy Studies Review*, 6(3), 1987:459-475.

Mayer, Jeffrey P., Blakely, Craig H. and Davidson II, William S. Social program innovation and dissemination: A study of organizational change processes. *Policy Studies Review*, 6(2), 1986:273-286.

Mayntz, Renate. Public bureaucracies and policy implementation. *International Social Science Journal*, 31(4), 1979:633-645.

Mayntz, Renate. The conditions of effective public policy: A new challenge for policy analysis. *Policy and Politics*, 11(2), 1983:123-143.

McWhinney, Ian R. Fine words, but will he deliver? *Canadian Medical Association Journal*, 136, March 1, 1987:473-475.

Milio, N. Multisectoral policy and health promotion: where to begin? *Health Promotion*, 1(2), 1986c:129-132.

Nonneman, W. and Doorslaer, E. Van. Economic incentives in the health care industry: Implications for health policy making. *Health Policy*, 7, 1987:109-114.

O'Toole, Jr., Laurence. Policy recommendations for multi-actor implementation: An assessment of the field. *Journal of Public Policy*, 6(2), 1986:181-210.

Roberts, Jan and Colvin, Phyllis. Personal Communication, October 28, 1987.

Robertson, David Brian. Program implementation versus program design: What accounts for policy failure? *Policy Studies Review*, 3(3-4), 1984:391-405.

Sabatier, Paul A. Top-down and bottom-up approaches to implementation research: A critical analysis and suggested synthesis. *Journal of Public Policy*, 6(1), 1986:21-48.

Sabatier, Paul A. and Mazmanian, Daniel. The conditions of effective implementation: A guide to accomplishing policy objectives. *Policy Analysis*, 5(4), 1979:481-504.

Siler-Wells, Gail. An implementation model for health system reform. *Social Science and Medicine*, 24(10), 1987:821-832.

Spitzer, Robert J. Promoting policy theory: Revisiting the arenas of power. *Policy Studies Journal*, 15(4), 1987: 675-689.

Squires, Bruce P. Medical education to achieve Health for All. *Canadian Medical Association Journal*, 136, March 1, 1987:475-477.

Thain, Colin. Implementing economic policy: An analytical framework. *Policy and Politics*, 15(2), 1987:67-75.

Thrasher, Michael. Exchange networks and implementation. *Policy and Politics*, 11(4), 1983:375-391.

Wolman, Harold. The determinants of program success and failure. *Journal of Public Policy*, 1(4), 1981:433-464.

Woodside, Kenneth. Policy instruments and the study of public policy. *Canadian Journal of Political Science*, XIX(4), 1986:775-793.

INTERNATIONAL HEALTH SERVICES AND HEALTH PROMOTION DEVELOPMENTS:

Ashton, J., Grey, P. and Barnard, K. Healthy cities WHO's new public health initiative. *Health Promotion*, 1(2), 1986:129-133.

Ashton, J., Seymour, H., Ingledew, D., Ireland, R., Hopley, E., Parry, A., Ryan, M. and Holbourn, A. Promoting the new public health in Mersey. *Health Education Journal*, 45(3), 1986:174-179.

Bennett, F.J. Health revolution in Africa? *Social Science and Medicine*, 22(7), 1986:737-740.

Dahlgren, G. and Diderichsen, F. Strategies for equity in health: report from Sweden. *International Journal of Health Services*, 16(4), 1986:517-537.

Ekeid, S.E. *Health Services in Norway*. Oslo: The Directorate of Health, Norway.

Hancock, Trevor. Healthy public policy in the Nordic countries: Preliminary report. *Canadian Journal of Public Health*, 78, Jan./Feb. 1987c:9-10.

Health Care in Denmark. Copenhagen: Ministry of the Interior of Denmark, 1985.

Health in Sweden. Stockholm: The Swedish Ministry of Health and Social Affairs, 1982.

Healthy People. The Surgeon General's Report on Health Promotion and Disease Prevention. Washington, D.C.: U.S. Department of Health, Education and Welfare, 1979.

Intersectoral Action for Nutrition and Health, Norwegian Policy. Oslo: National Nutrition Council, 1982.

Klepp, K-I. and Forster, J.L. The Norwegian nutrition and food policy: an integrated policy approach to a public health problem. *Journal of Public Health Policy*, December 1985:447-463.

Last, J.M. Scenarios and methods to support long term health planning. *Canadian Journal of Public Health*, 78, Jan./Feb. 1987:11-12.

Leppo, K. and Vertio, H. Smoking control in Finland: A case study in policy formulation and implementation. *Health Promotion*, 1(1), 1986:5-16.

Lifestyle related diseases a major concern in Swedish health care planning. October 1980.

Malkas, T. Health effects of unemployment and national health policy in Finland. In G. Westcott, P.G. Svensson and H. Zollner (Eds.), *Health policy implications of unemployment*. Copenhagen: World Health Organization, Regional Office for Europe, 1985:357-368.

Milio, N. Promoting health through structural change: Analysis of the origins and implementation of Norway's farm-food-nutrition policy. *Social Science and Medicine*, 15A, 1981:721-734.

Shultz, J.M., Moen, M.E., Pechacek, T.F., Hart, K.C., Skubic, M.A., Gust, S.W. and Dean, A.G. The Minnesota plan for nonsmoking and health: The legislative experience. *Journal of Public Health Policy*, Autumn 1986: 300-313.

Thompson, E.B., Hamrell, M. and Coffin, R.R. The Heart Healthy Vermonter Program. *Journal of Public Health Policy*, Spring 1987:36-43.

LOCAL INITIATIVES IN HEALTHY PUBLIC POLICY:

Ashton, J., Grey, P. and Barnard, K. Healthy cities WHO's new public health initiative. *Health Promotion*, 1(2), 1986:129-133.

Ashton, John. Healthy Cities A World Health Organization project. Unpublished manuscript, 1986.

City of Toronto Department of Public Health. Memorandum to Board of Health concerning the Establishment of an Environmental Protection Office within the Department of Public Health. February 10, 1987.

Duhl, L.J. The healthy city: its function and its future. *Health Promotion*, 1(1), 1986b:55-60.

Farrant, Wendy. Health for All in the Inner City. Proposed Framework for a Community Development Approach to Health Promotion Policy and Planning at District Level. District Health Promotion Group, Paddington and North Kensington Health Authority, 1986.

Hancock, T. and Duhl, L. *Healthy Cities: Promoting Health in the Urban Context*. Background working paper for the "Healthy Cities Symposium", Lisbon, Portugal, April 7-11, 1986.

Hancock, Trevor. Healthy Toronto 2000: A vision of a healthy city. Unpublished manuscript, 1987b.

Haughton, B. Developing local food policies: One city's experiences. *Journal of Public Health Policy*, Summer 1987:180-191.

Healthy Toronto 2000. Toronto: Healthy Toronto 2000 Subcommittee, Board of Health, August 1987.

Macpherson, Alexander S. Personal interview, November 18, 1987.

Seymour, H., Ashton, J. and Edwards, P. Health museums or theme parks: a new approach to intersectoral collaboration. *Health Promotion*, 1(3), 1986:311-317.

PARTICIPATION:

Arnstein, Sherry R. A ladder of citizen participation. *AIP Journal*, July 1969:216-224.

Bjorkman, James Warner. Who governs the health sector? Comparative European and American experiences with representation, participation and decentralization. *Comparative Politics*, July 1985a:399-420.

Bruton, M.J. Public participation. local planning and conflicts of interest. *Policy and Politics*, 8(4), 1980:423-442.

Checkoway, Barry, O'Rourke, Thomas W. and Bull, David. Correlates of consumer participation in health planning agencies: Findings and implications from a national survey. *Policy Studies Review*, 3(2), 1984:296-310.

Cohen, Jean L. Rethinking social movements. *Berkeley Journal of Sociology*, XXVIII, 1983:97-113.

Diem, Elizabeth C. The 1983 Ontario Minister of Health's Policy Conference: Assessing the benefits and risks of formal consultation. M.Sc. Thesis, University of Toronto, 1985.

Duncan, Graeme (ed.). *Democratic Theory and Practice*. Cambridge: Cambridge University Press, 1983.

Edwards, John N. and White, Randall P. Predictors of social participation: Apparent or real? *Journal of Voluntary Action Research*, 9(1-4), 1980:60-73.

Gittel, Marilyn. The consequences of mandating citizen participation. *Policy Studies Review*, 3(1), 1983:90-95.

Mulgan, R.C. Who should have how much say about what? Some problems of pluralist democracy. *Political Science*, 36(2), 1984:112-124.

Nanetti, Rafaela Y. From the top-down: Government promoted citizen participation. *Journal of Voluntary Action Research*, 9(1), 1980:149-164.

Nanetti, Rafaela Y. Neighbourhood institutions and policy outputs: The Italian case. *International Journal of Urban and Regional Research*, 9(1), 1985:113-135.

Parker, Robert Nash. Measuring social participation. *American Sociological Review*, 48(6), 1983:864-873.

Riddick, Carol Outler, Cordes, Sam, Eisele, Tura and Montgomery, Alison. The health planning process: Are consumers really in control? *Health Policy*, 4, 1984:117-127.

Sills, P., Marsden, D. and Taylor, M. Decentralization: Current trends and issues. *Community Development Journal*, 21(2), 1986:84-87.

Stein, Arlene. Between organization and movement: ACORN and the Alinsky model of community organizing. *Berkeley Journal of Sociology*, XXXI, 1986:93-115.

Van Til, Jan. Citizen participation in the future. *Policy Studies Review*, 3(2), 1984:312-322.

Vuori, Hannu. Overview Community participation in primary health care: A means or an end? *Public Health Review*, 12, 1984:331-339.

POLICY DESIGN:

Dryzek, John S. Don't toss coins in garbage cans: A prologue to policy design. *Journal of Public Policy*, 3(4), 1983:345-368.

Ingraham, Patricia W. Toward more systematic consideration of policy design. *Policy Studies Journal*, 15(4), 1987:611-628.

Laumann, Edward O., Knoke, David and Kim, Yong-Hak. An organizational approach to state policy formation: A comparative study of energy and health domains. *American Sociological Review*, 50, February 1985:1-19.

Linder, Stephen H. and Peters, B. Guy. From social theory to policy design. *Journal of Public Policy*, 4(3), 1984:237-259.

POLICY-MAKING UNDER UNCERTAINTY:

Dror, Yehezkel. *Polymaking under Adversity*. New Brunswick, New Jersey: Transaction Books, 1986.

Duhl, Leonard J. *Health Planning and Social Change*. New York: Human Sciences Press, 1986a.

Emery, F.E. and Trist, E.L. *Towards a Social Ecology*. New York: Plenum/Rosetta, 1973.

Gemmill, Gary and Smith, Charles. A dissipative structure model of organization transformation. *Human Relations*, 38(8), 1985:751-766.

Hunter, David J. *Coping with Uncertainty: Policy and Politics in the National Health Service*. Chichester: Research Studies Press, 1980.

Jackson, Suzanne F. Planning for Health in a Changing Society: A study of the relationship between a changing social paradigm, turbulence, non-conventional health care practices and planning. Ph.D. Thesis, University of Waterloo, 1981.

McWhinney, Will. The resolution of complex issues. Draft unpublished manuscript, 1980.

Morgan, Gareth and Ramirez, Rafael. Action learning: Metaphor for guiding social change. *Human Relations*, 37(1), 1983:1-28.

Morgan, Gareth. Chapter 1: Emerging Managerial Competencies, Draft, in *Riding the Cutting Edge of Change: Emerging Managerial Competencies*. San Francisco: Jossey-Bass, 1988.

Pava, Calvin. Towards a Concept of Normative Incrementalism: One prospect for purposeful non-synoptic change in highly fragmented social systems. Ph.D. Thesis, University of Pennsylvania, 1980.

Ziglio, Erio. Uncertainty and innovation in health policy: The Canadian and Norwegian approaches to health promotion. Ph.D. Thesis, University of Edinburgh, 1985.

Ziglio, Erio. Uncertainties and dilemmas in future health policy scenarios: Some cautionary issues. *Futures Research Quarterly*, 2(4), 1986a:5-15.

Ziglio, Erio. Uncertainty in health promotion: Nutrition policy in two countries. *Health Promotion*, 1(3), 1986b:257-268.

Ziglio, Erio. Policy-making and planning in conditions of uncertainty: Theoretical considerations for health promotion policy. Working Paper #7, Research Unit in Health and Behavioural Change, University of Edinburgh, 1987a.

POLICY OVERVIEW:

Balfe, Bruce E., Beiber, Gail, Boyle, Joseph F., Brochi, Severine J. and Lane, Kathren R. A health policy agenda for the American people: The issues and their development. *Journal of the American Medical Association*, 256(8), 1986:1021-1023.

Blumstein, James F. and Zubkoff, Michael. Public choice in health: Problems, politics and perspectives on formulating national health policy. *Journal of Health Politics, Policy and Law*, 4(3), 1979:382-413.

Campbell, Alan G. The application of science to health policy-making. *Health Management Forum*, 4(3), 1983:50-59.

Crichton, Anne. *Health Policy Making*. Ann Arbor: Health Administration Press, 1981.

Diesing, Paul. *Science and Ideology in the Policy Sciences*. New York: Aldine Publishers, 1982.

Dror, Yehezkel. *Design for Policy Sciences*. New York: American Elsevier Publishing Company Inc., 1971.

Ham, Christopher. Approaches to the study of social policy making. *Policy and Politics*, 8(1), 1980:55-71.

Ham, Christopher. *Health Policy in Britain*. Houndmills, Basingstoke, Hampshire: MacMillan Publishers, 1985.

Hill, Michael and Ham, Christopher. *The Policy Process in the Modern Capitalist State*. Brighton, Sussex: Wheatsheaf Books, 1984.

Kaprio, Leo A. A view on national health policy. *Health Policy*, 5, 1985:171-172.

Lee, Kenneth and Mills, Anne. *Policy-making and Planning in the Health Sector*. London: Croon Helm, 1982.

Lindblom, C.E. How to think about the policy-making process. Unpublished work, not to be cited without permission, 1986.

Nagel, Stuart S. *Public Policy: Goals, Means and Methods*. New York: St. Martin's Press, 1984.

Navarro, Vincente. Federal health policies in the United States: An alternative explanation. *The Milbank Quarterly*, 65(1), 1987:81-111.

Paul, Ellen Frankel and Russo, Jr., Philip A. *Public Policy: Issues, Analysis and Ideology*. Chatham, N.J.: Chatham Publishers Inc., 1982.

Wildavsky, Aaron. *Speaking Truth to Power: The Art and Craft of Policy Analysis*. Boston: Little, Brown and Company, 1979.

Wittrock, Bjorn and DeLeon, Peter. Policy as a moving target: A call for conceptual realism. *Policy Studies Review*, 6(1), 1986:44-60.

RECONCEPTUALIZING HEALTH POLICY:

Brewer, Gary D. Policy Sciences, the Environment and Public Health. Unpublished paper prepared for a Symposium on Healthy Public Policy, Yale University, October 1987.

Hancock, Trevor. Beyond health care: Creating a healthy future. *The Futurist*, XVI(4), 1982:4-13.

Stewart, Gail Ward. The Leading Question: A Paper Related to a Project on Economics and Environment. Unpublished paper, property of the author, Ottawa, Ontario, 1984a.

Stewart, Gail Ward. Gaining perspective on environmental issues: A fresh look at familiar problems. *Focus*, 10(1), 1984b:14-16.

REFLECTIONS ON A NEW PERSPECTIVE ON THE HEALTH OF CANADIANS:

Evans, Robert. A Retrospective on the "New Perspective". *Journal of Health Policy, Politics and Law*, 7(2), 1982:325-344.

Hancock, Trevor. Lalonde and beyond: Looking back at "A New Perspective on the Health of Canadians". *Health Promotion*, 1(1), 1986a:93-100.

Terris, M. Newer perspectives on the health of Canadians: beyond the Lalonde Report. *Journal of Public Health Policy*, 5(3), 1984: 327-337.

RESEARCH AND EVALUATION:

Albrecht, G. and Johnson, D. The social context of policy research. *Sociological Methods and Research*, 13(3), Feb. 1985:275-287.

Asvall, J.E., Jardell, J.-P. and Nanda, A. Evaluation of the European strategy for Health for All by the Year 2000. *Health Policy*, 6, 1986:239-258.

Atal, Y. Using the social sciences for policy formulation. *International Social Science Journal*, 35(2), 1983:367-378.

Attinger, E. Dynamic Modeling and Health Policy Research. Methodological Foundations for Research on the Determinants of Health Development, Proceedings of an Informal Consultation, Geneva: World Health Organization, 1985.

Barrett, Susan and Hill, Michael. Policy, bargaining and structure in implementation theory: Towards an integrated perspective. *Policy and Politics*, 12(3), 1984:219-240.

Berk, R., Boruch, R., Chambers, D., Rossi, P. and Witte, A. Social policy experimentation: A position paper. *Evaluation Review*, 9(4), August 1985:387-429.

Bridgers, W. A brief chapter in the politics of prevention research. Editorial, *Journal of Public Health Policy*, March 1985:5-9.

Brown, V. Towards an epidemiology of health: A basis for planning community health programs. *Health Policy*, 4, 1985:331-340.

Campbell, D. Reforms as experiments. *American Psychologist*, 24(4), 1969:409-429.

Davis, K. Research and policy formulation. Editorial, *Health Policy*, 7, 1987:295-296.

Dror, Yehezkel. Some features of a meta-model for policy studies. *Policy Studies Journal*, 3(3), Spring 1975:247-255.

Emery, Merrelyn and Emery, Fred. Searching for new directions, in new times...in new ways. In J.W. Sutherland (ed.), *Handbook for Public Administrators*. New York: Van Nostrand Reinhold, 1978: 257-301.

Frank, J. Public health policy and the quality of epidemiological evidence: How good is good enough? *Journal of Public Health Policy*, Sept. 1985:314-321.

Glenn, Norval D. *Cohort Analysis*. Beverly Hills and London: Sage, 1977.

- Gogstad, A. The use of social background data in social medicine research. *Scandinavian Journal of Social Medicine*, 14, 1986:49-50.
- Graham, G. and Graham, S. Macroevaluation: Framework for a policy system. *Policy Studies Journal*, 3(3), 1975:262-268.
- Himmelstrand, U. Ideology, science and policy impact: Thoughts on the tasks and challenges of the social sciences. *International Social Science Journal*, 34, 1982:503-516.
- Hunt, S. Food and fibre in a Scottish community. *Health Education Research*, 2(3), 1987:223-229.
- Jones, L. and Baker, M. The application of health economics to health promotion. *Community Medicine*, 8(3), 1986:224-229.
- Kerlinger, F. *Foundations of Behavioral Research*. 2nd edition, New York: Holt, Rinehart and Winston, Inc., 1973.
- Klein, Rudolf. Evaluation and social policy: Some reflections on ideas and institutions. *Evaluation and Program Planning*, 5, 1982:133-140.
- Knox, P. Subjective Social Indicators and Urban Social Policy: A Review. *Policy and Politics*, 7(3), 1979:299-309.
- Mark, M. and Shotland, R. Lance. Stakeholder-based evaluation and value judgments. *Evaluation Review*, 9(5), 1985:605-625.
- McQueen, D. Research in Health Behaviour, Health Promotion and Public Health. Working Paper, #6, Research Unit in Health and Behavioural Change, University of Edinburgh, 1987.
- McQueen, D., Roberts, M., Robertson, G., Loudon, N. and Shepard, C. A women's health shop: A practical example of health education and health promotion. *Health Education Research*, 2(3), 1987:239-244.
- Means, R. Some ethical and practical problems in the construction of policy recommendations from implementation research. *Policy and Politics*, 10(2), 1982:205-215.
- Mergler, D. Worker participation in occupational health research: Theory and practice. *International Journal of Health Services*, 17(1), 1987:151-167.
- Milio, Nancy. Personal Interview. October 28, 1987b.
- Mitroff, I. and Sagasti, F. Epistemology as general systems theory: An approach to the design of complex decision-making experiments. *Philosophy and Social Science*, 3, 1973:117-134.
- Mootz, M. Health indicators. *Social Science and Medicine*, 22(2), 1986:255-263.
- O'Toole, Laurence J. Policy recommendations for multi-actor implementation: An assessment of the field. *Journal of Public Policy*, 6(2), 1986:181-210.
- Palumbo, Dennis J., Fawcett, Stephen B. and Wright, Paula. *Evaluating and Optimizing Public Policy*. Lexington, Massachusetts: Lexington Books, 1981.
- Parker, Barnett R. and Lassner, Karen Johnson. Heuristic approaches to decision-making in the delivery of primary health care within developing regions. *Journal of Health Policy, Politics and Law*, 10(1), 1985:157-180.
- Planning and management for Health*. Report on a European conference, The Hague, 27 August 1 September, 1984. Euro Reports and Studies 102. Copenhagen: World Health Organization, Regional Office for Europe, 1984.
- Research in Health Promotion: Priorities, Strategies, Barriers*. World Health Organization. Report on a joint WHO/SHEG workshop, Edinburgh, Nov. 5-7, 1984.
- Robins, J., Landrigan, P., Robins, T. and Fine, L. Decision-making under uncertainty in the setting of environmental health regulations. *Journal of Public Health Policy*, Sept. 1985:322-328.
- Sabatier, Paul A. Top-down and bottom-up approaches to implementation research: A critical analysis and suggested synthesis. *Journal of Public Policy*, 6(1), 1986:21-48.
- Seidel, A. Producing usable research: A selected review. *Policy Studies Review*, 3(1), August 1983:52-56.
- Shortell, S. Improving health care policy research. *Journal of Health Politics, Policy and Law*, 6(4), 1982:681-701.
- Susman, G. and Evered, R. An assessment of the scientific merits of action research. *Administrative Science Quarterly*, 23, December 1978:582-603.
- Terris, M. Health policy and the quality of the evidence: Introduction. *Journal of Public Health Policy*, September 1985:307-312.
- Thain, Colin. Implementing economic policy: An analytical framework. *Policy and Politics*, 15(2), 1987:67-75.
- Thomas, Patricia. Social research and government policy. In Martin Loney et al. (eds.), *Social Policy and Social Welfare*. Milton Keynes: Open University Press, 1983:117.
- Topalov, Christian. Social policies from below: A call for comparative historical studies. *International Journal of Urban and Regional Research*, 9(2), 1985:254-271.

Tornatzky, Louis G. and Johnson, Elmima C. Research on implementation: Implications for evaluation practice and evaluation policy. *Evaluation and Program Planning*, 5, 1982:193-198.

van Etten, G. and Rutten, F. The social sciences in health policy and practice. *Social Science and Medicine*, 22(11), 1986:1187-1194.

Vertio, Harri. Healthy Cities. Promoting Health in the Urban Context: Dimensions and Indicators. Background paper prepared for the Healthy Cities Symposium, Lisbon, Portugal, April 7-11, 1986.

Vuori, H. WHO A source of inspiration for researchers? *Scandinavian Journal of Social Medicine*, 15, 1987:57-61.

Walker, B. The role of statistics in state health policy decisions: The Massachusetts experience. *Journal of Public Health Policy*, Spring 1986:12-20.

Wilde, Keith. The establishment of futures thinking in government service. *Futures Canada*, 1987:18-21.

Williams, S. and Wysong, J. Health services research and health policy formulation: An empirical analysis and a structural solution. *Journal of Health Politics, Policy and Law*, 2, 1977:362-387.

Wittrock, Bjorn and DeLeon, Peter. Policy as a moving target: A call for conceptual realism. *Policy Studies Review*, 6(1), 1986:44-60.

Ziglio, Erio. Health Policy Study: Stimulus Protocol. Stimulus paper prepared for WHO meeting on health promotion research, October 4-6, 1987b, Edinburgh, Scotland.

ROLE OF HEALTH CARE PROFESSIONS IN HEALTH PROMOTION:

Fowler, G. Health education in general practice. *Health Education Journal*, 44(1), 1985:44-45.

Jaffe, E. The role of occupational therapy in disease prevention and health promotion. *The American Journal of Occupational Therapy*, 40(11), 1986:749-752.

Miller, C. Arden. An agenda for public health departments. *Journal of Public Health Policy*, June 1985:158-171.

Roemer, M.I. The value of medical care for health promotion. *American Journal of Public Health*, 74(3), 1984:243-247.

Squires, B.P. Medical education to achieve health for all. *Canadian Medical Association Journal*, 136, March 1, 1987: 474-475.

Terris, M. Health promotion and disease prevention: What can medical schools contribute? *Forum*, XX(5), 1987:1-5.

STRATEGIES:

Angus, D.E. and Manga, P. National health strategies: time for a new "New Perspective". *Canadian Journal of Public Health*, 77, Mar./April 1986:81-85.

Dahlgren, Goran and Dieckrichsen, Finn. Strategies for equity in health: Report from Sweden. *International Journal of Health Services*, 16(4), 1986:517-537.

Epp, Jake. National strategies for health promotion. *Canadian Journal of Public Health*, 77, July/August 1986:243-247.

Lamb, Jr., Charles. Public sector marketing is different. *Business Horizons*, July/August, 1987:56-60.

Mason, Richard O. A dialectical approach to strategic planning. *Management Science*, 15(3), 1968:403-414.

Porter, Michael. The case for rethinking strategic planning. *Globe and Mail*, June 8, 1987:B1,B6.

(A) *Proposal to Establish Health Objectives and Strategies for Canada*. Canadian Public Health Association, Ottawa, Ontario, 1985.

Quinn, James Brian. Strategic goals: Process and politics. *Sloan Management Review*, Fall 1977:21-37.

Solesbury, William. Strategic planning: Metaphor or method? *Policy and Politics*, 9(4), 1981:419-437.

VISION, VALUES AND GOALS:

Addiss, S.S. Setting goals and priorities: 1984 Presidential address. *American Journal of Public Health*, 75(11), 1985:1276-1280.

Becker, M. The tyranny of health promotion. *Public Health Reviews*, 14, 1986: 15-25.

Bjorkman, James Warner. Equity and social policy: conceptual ambiguity in welfare criteria. *International Journal of Sociology and Social Policy*, 5(2), 1985b:16-32.

Dunn, William N. (ed.) *Values, ethics and the practice of policy analysis*. Lexington, Massachusetts: Lexington Books, 1982.

Gish, Oscar. Values in health care. *Social Science and Medicine*, 19(4), 1984:333-339.

Goodman, L.E. and Goodman, M.J. Prevention how misuse of a concept undercuts its worth. *Hastings Center Report*, April 1986:26-38.

Gunning-Schepers, Louise J. Health for all by the year 2000: A mere slogan or a workable formula? *Health Policy*, 6, 1986:227-237.

Jackson, Ray W. *Human Goals and Science Policy*. Science Council of Canada Background Study No. 38, 1976.

Kemm, J.R. The ethics of food policy. *Community Medicine*, 7, 1985:289-294.

Last, J. The ethics of paternalism in public health. *Canadian Journal of Public Health*, 78, Jan./Feb. 1987:3-4.

McKnight, John. Regenerating community. *Social Policy*, Winter 1985:54-58.

Musheno, Michael C. The justice motive in the social policy process: Searching for normative rules of distribution. *Policy Studies Review*, 5(4), 1986:697-704.

Robinson, James C. Philosophical origins of the economic valuation of life. *The Milbank Quarterly*, 64(1), 1986:133-155.

Smith, Christopher J. Equity in the distribution of health and welfare services: Can we rely on the State to reverse the 'inverse care law'? *Social Science and Medicine*, 23(10), 1986:1067-1078.

Spasoff, R.A. Health goals and the public health. *Canadian Journal of Public Health*, 78(5), 1987:291-292.

Terris, Milton. Newer perspectives on the Health of Canadians: Beyond the Lalonde Report. *Journal of Public Health Policy*, September 1984:327-337.

Terris, Milton. Redefining the public health agenda. *Journal of Public Health Policy*, Summer 1987:151-163.

Weale, Albert. Issues of value and principle in social policy. In Martin Loney, David Boswell and John Clarke (eds.), *Social Policy and Social Welfare*. Milton Keynes: Open University Press, 1983.

VOLUNTARY ASSOCIATIONS AND ORGANIZATIONS:

Health: a need for redirection. Canadian Medical Association, Task Force on the Allocation of Health Care Resources. Toronto, 1984.

(A) *Proposal to Establish Health Objectives and Strategies for Canada*. Discussion paper submitted by the Canadian Public Health Association with support and assistance from the Ontario Public Health Association, September 1985.

Tejada-de-Rivero, D.A. Meeting the challenge of health for all: The indispensable contribution of national public health associations. *Public Health Review*, 12, 1984:208-212.

(A) *Vision for A Healthy Ontario*. Paradigm Health. July 1986.

Vuori, H. Health for all and public health. *Canadian Journal of Public Health*, 76, Jan./Feb. 1985:13-16.

White, F. A voluntary perspective on health promotion: the role of non-governmental organizations, particularly in the voluntary sector. *Canadian Journal of Public Health*, 77, Nov./Dec. 1986:431-436.